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AUTHOR Gaudin, James M., Jr.

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ABSTRACT

This manual provides a state-of-the art review of child neglect in the United States, its nature, causes, and the implications of that knowledge for preventive and remedial intervention. After an introduction, the first chapter considers the definition of neglect including types of neglect, the withholding of medically indicated treatment from newborns, prenatal exposure to drugs, failure to thrive/malnutrition, and chronic versus "new" neglect. The next chapter discusses the causes of neglect including parents' developmental history and personality factors, characteristics of children and family system factors, contextual sources of stress and support, informal support systems, and stress. The third chapter examines short-term and long-term consequences of neglect at various ages as well as mediating effects and neglect-related child fatalities. A chapter on assessment of neglect notes indicators, causes of and barriers to adequate care, and structured assessment measures. An exhaustive chapter on intervention covers the following: (1) general guidelines, (2) interventions to remedy neglect, (3) multiservice interventions, (4) family-focused interventions, (5) family preservation services, (6) group approaches, (7) treatment of neglected children, (8) legal intervention, and (9) preventing burnout. The next to last chapter, on prevention of neglect, considers primary, secondary, and tertiary prevention. The final chapter addresses social policy implications such as attention to poverty, improvements in public social utilities, and service delivery systems. A glossary is provided. (Contains 63 references.) (DB)

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National Center on Child Abuse and Neglect

Child Neglect: A Guide for Intervention

The User Manual Series

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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CHILD NEGLECT:
A GUIDE FOR INTERVENTION

James M. Gaudin, Jr., Ph.D.

April 1993

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement systems to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) designed to provide guidance to professional involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Some manuals described professional roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics—for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were first developed. This increased knowledge has improved our ability to intervene effectively in the lives of "at risk" children and their families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles of the key professionals involved in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals which address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

This manual, *Child Neglect: A Guide for Intervention*, provides a state-of-the-art review of existing knowledge about child neglect in the United States, its nature, causes, and the implications of that knowledge for preventive and remedial intervention. It offers direction, based upon the findings from empirical research, for child welfare practitioners, supervisors, program managers, and policy makers concerned about reducing the incidence and damaging developmental effects of child neglect upon its young victims.

ACKNOWLEDGMENTS

James Gaudin, Jr., Ph.D., is Professor and Director of the Research Center at the University of Georgia School of Social Work. He has conducted research, published over 25 articles, and conducted numerous workshops on child neglect over the past 13 years. His social work practice experience over the past 28 years includes clinical practice with families and children, supervision, consultation, social planning, research, and teaching.

The following were members of the Advisory Panel for Contract No. HHS-105-89-1730:

Nainan Thomas, Ph.D.
Child Welfare Division
Prince George's County
Department of Social Services
Hyattsville, MD

Shirley Davis
Child Development and Family
Guidance Center
St. Petersburg, FL

Michael Nunno
Family Life Development Center
Ithaca, NY

Peter Correia
University of Oklahoma
Tulsa, OK

Howard Davidson
American Bar Association
Washington, DC

Anthony Urquiza
University of California
Sacramento, CA

Janet Hutchinson
University of Pittsburgh
Pittsburgh, PA

Judee Filip
National Resource Center
Child Abuse and Neglect
Denver, CO

John Holton
Greater Chicago Council for
the National Committee for
the Prevention of Child Abuse

Sandra Hodge
Department of Human Services
Augusta, ME

Marsha K. Salus
Chair
User Manual Advisory Panel
Alexandria, VA

INTRODUCTION

Everyone in the child protective services (CPS) agency knows the Edwards family. Mr. and Mrs. Edwards and their four children, now ages 8–14, first came to the agency's attention 9 years ago. At that time, the family was on the brink of eviction from their apartment, rent had not been paid for 2 months, the children were not in school, and Mrs. Edwards was pregnant again.

Over the years, despite numerous and frequent crises, the CPS agency has managed to keep the Edwards family together. Maintaining the family has not been easy. Reports of child neglect (e.g., not sending the children to school, missed medical appointments) have surfaced intermittently. Nearly every resource in the agency and community has been tapped at some point in time to meet the family's needs.

Currently, Mr. Edwards is involved in a treatment program for alcoholism, Mrs. Edwards is receiving job training, and the children are doing fairly well in school. While there are signs of progress, the CPS caseworker knows that, at any moment, the Edwards case can "erupt" again.

Another family—the Allen family—is new to the CPS agency. Today, a neighbor reported that Mrs. Allen, a recently divorced 20-year-old, "went out" last night and left her 2-year-old daughter alone. The neighbor heard the toddler crying, entered the unlocked apartment, and cared for the child until Mrs. Allen returned. The neighbor believes that Mrs. Allen is "on drugs."

Child neglect, as exemplified in the Edwards and Allen families, is the most frequently identified type of child maltreatment in the United States. Some families, such as the Edwards, have multiple problems, often requiring long-term CPS intervention. Other families, such as the Allens, may only require short-term CPS intervention. Supportive services, such as child care, single parent support groups, parenting education, and the CPS caseworker's helping relationship, are some ways in which stress can be reduced in the life of a young family. Hopefully, Mrs. Allen will receive the services she needs to prevent the recurrence of child neglect.

Generally, child neglect means the failure of a parent or a caretaker responsible for the child's care to provide minimally adequate food, clothing, shelter, supervision, and/or medical care for the child. Defining "minimally adequate" levels of care, and reaching consensus on these definitions, however, are not easy processes. (See the discussion in the following chapter.) While the debate on definition continues, there is no doubt that child neglect is widespread and serious.

In the 1988 *Study of National Incidence and Prevalence of Child Abuse and Neglect*, commissioned by the National Center on Child Abuse and Neglect, 64 percent of the projected number of actual cases of child maltreatment in the United States were cases of child neglect.[1] Specifically, the study estimated 917,200 cases of child neglect or an estimated incidence rate of 14.6 per 1,000 children. In contrast, the estimated incidence rate for physical abuse was 4.9 per 1,000 children and 2.1 per 1,000 for sexual abuse. (These estimates are based on child maltreatment recognized by teachers, physicians, social workers, hospital personnel, police, and other community professionals, rather than on official reports made to CPS agencies.)

Even though child neglect is the most frequently identified form of child maltreatment in the United States, community concern about neglectful families lags far behind the concern shown for abusive families. In varying degrees, the neglecting family is a victim of societal neglect. Community service systems must become more responsive to the basic needs of neglecting families; for example, by providing safe, stable, and affordable housing, medical care, and child care. Community efforts also must be directed toward prevention, the strengthening of families, early intervention, and on the alleviation of social problems, such as substance abuse, which contribute to the child neglect. Much more, too, must be done for children who are the victims of neglect. Programs and services targeting neglected children show great promise in alleviating the ramifications of child neglect.

The following chapters are aimed at increasing understanding of child neglect—its manifestations, causes, and effect—and of ways to assess, intervene, and prevent the problem.

DEFINING NEGLECT

Differences in definitions of child neglect in State laws and in community standards reflect the significant variations in the judgments of professionals and nonprofessionals concerning what constitutes child neglect. Some State statutes emphasize the condition of the child without any mention of parental fault; others stress the condition of the child resulting from parental actions or fault. Some communities have determined that no child under age 10 should be left at home alone, while other communities "permit" working parents to leave their children unsupervised after school.

Defining neglect is complicated by the necessity of considering the following:

- What are the indispensable, minimally adequate types of care that children require?
- What actions or failures to act on the part of the parents or other caretaker constitute neglectful behavior?
- Must the parent's or caretaker's action or inaction be intentional, willful or not?
- What are the effects of the actions or inactions on the child's health, safety, and development?
- Is the family's situation a result of poverty, or a result of parental neglect?

Legal advocates have suggested that definitions of neglect which focus only on the behavior of the parent or caretaker are inadequate.[2] They strongly advocate that the parents' behavior must result in some *specific* physical damage or impairment or some identifiable symptoms of emotional damage to a child resulting from the parents' behavior or failure to act.[3] Some researchers have also included resultant damage to the physical, emotional, or intellectual development and well-being of the child in the definitions of neglect.[4] Zuravin has concluded, on the contrary, that the focus should be on the actions of the parents, not on the consequences of their behavior, nor on their intent or culpability.[5] Parents who leave preschool-aged children without adult supervision for an hour or more are neglectful, regardless of their intent, or whether the child suffers serious injury or not.

Conceptual definitions of neglect vary, in part, depending on the purpose for which the definition is used. Legal advocates insist on clear evidence of serious harm to a child before court intervention to remove a child from parents. On the other hand, for caseworkers intervening with a family to prevent placement and to protect the child from further harm, the definition of neglect must focus on parental omissions in care that are likely to increase the risk of harm to the child. For researchers interested in studying the long- and short-term consequences of neglect for the child, definitions of neglect would need to focus on parental behaviors that result in harm to the child.

Polansky's conceptual definition of child neglect is widely accepted:

> "A condition in which a caretaker responsible for the child, either deliberately or by extraordinary inattentiveness, permits the child to experience avoidable present suffering and/or fails to provide

one or more of the ingredients generally deemed essential for developing a person's physical, intellectual, and emotional capacities."[6]

This definition meets the demand for inclusion of parental actions, which result in some negative consequences for the child, but fails to specify the required degree of harm to the child. The problem comes in defining what is "generally deemed essential" for a child's physical, intellectual, and emotional development. This definition is heavily dependent upon the ever-changing status of our knowledge about what is physically and psychologically essential for a child's healthy growth and development.

There is a lack of consensus among parents and even among child development researchers on what is essential for child development. Standards of what is essential continue to change as we learn more about child development and those things that impede or enhance children's physical, cognitive, emotional, and social development. For example, the legal requirement that children be restrained in car seats clearly defines a new standard for "minimally adequate care" of children while traveling in cars.

These operational definitions of neglect are highly dependent upon the standards of the local community and of the caseworker who investigates reports of neglect. However, infants and very young children left without adult supervision for hours, children who are not fed regularly, children who are not taken for necessary medical treatment when ill, chronically dirty, lice-infested children, or chronically truant children are consistently accepted as having experienced neglect.

Definitions of what is minimally adequate care or, conversely, inadequate care for children, must also take into account cultural variations in standards for adequate care of children.[7] Significant differences in ratings of the severity of specific indicators of abuse and neglect among social workers, police, attorneys, and judges and among African-American, Hispanic, and white subjects were discovered in one study.[8] African-American subjects rated indicators of physical neglect as significantly more severe instances of inadequate care than did whites or Hispanics. On the other hand, another study concluded that when presented with critical incidents descriptive of child neglect, there was substantial agreement among white, Hispanic, and African-American subjects on basic standards of care for children.[9] Clearly, cultural variations require further consideration in practice and in research.

Poverty is a significant confounding factor in defining child neglect. Although most impoverished families manage to provide strong, nurturing care for their children, the association of child neglect with poverty is clearly supported by many studies.[10] Families receiving Aid to Families with Dependent Children (AFDC) are often reported for neglect. Even among impoverished families, neglectful families are the "poorest of the poor," often lacking adequate housing, health care, and child care.[11]

The difficulty comes in establishing the parents' accountability for providing minimally adequate necessities for their children, such as after school supervision and medical care, in the face of inadequate income, and the absence of accessible, affordable medical and supportive social services. Some State laws specifically exempt inadequate child care because of poverty from the definition of neglect by adding the clause "in spite of availability." Working parents without health insurance may find medical care for their children beyond their resources. Nevertheless, children who are deprived of medical treatment when they are ill are being neglected, regardless of the cause.

TYPES OF NEGLECT

The *Study of National Incidence and Prevalence of Child Abuse and Neglect*[12] sought to overcome the problem of nonuniform definitions of child neglect by utilizing a standard definition of neglect. The definitions of neglect included physical neglect, child abandonment and expulsion, medical neglect, inade-

quate supervision, emotional neglect and educational neglect by parents, parent substitutes, and other adult caretakers of children. The NIS definitions are categorized as follows:

Physical Neglect

Refusal of Health Care	Failure to provide or allow needed care in accord with recommendations of a competent health care professional for a physical injury, illness, medical condition, or impairment.
Delay in Health Care	Failure to seek timely and appropriate medical care for a serious health problem which any reasonable layman would have recognized as needing professional medical attention.
Abandonment	Desertion of a child without arranging for reasonable care and supervision. This category included cases in which children were not claimed within 2 days, and when children were left by parents/substitutes who gave no (or false) information about their whereabouts.
Expulsion	Other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others, or refusal to accept custody of a returned runaway.
Other Custody Issues	Custody-related forms of inattention to the child's needs other than those covered by abandonment or expulsion. For example, repeated shuttling of a child from one household to another due to apparent unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time.
Other Physical Neglect	Conspicuous inattention to avoidable hazards in the home; inadequate nutrition, clothing, or hygiene; and other forms of reckless disregard of the child's safety and welfare, such as driving with the child while intoxicated, leaving a young child unattended in a motor vehicle, and so forth.

Supervision

Inadequate Supervision	Child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the parent/substitute knowing (or attempting to determine) the child's whereabouts.

Emotional Neglect

Inadequate Nurturance/Affection	Marked inattention to the child's needs for affection, emotional support, attention, or competence.
Chronic/Extreme Abuse or Domestic Violence	Chronic or extreme spouse abuse or other domestic violence in the child's presence.

Permitted Drug/Alcohol Abuse	Encouraging or permitting drug or alcohol use by the child; cases of the child's drug/alcohol use were included here if it appeared that the parent/guardian had been informed of the problem and had not attempted to intervene.
Permitted Other Maladaptive Behavior	Encouragement or permitting of other maladaptive behavior (e.g., severe assaultiveness, chronic delinquency) in circumstances in which the parent/guardian had reason to be aware of the existence and seriousness of the problem but did not attempt to intervene.
Refusal of Psychological Care	Refusal to allow needed and available treatment for a child's emotional or behavioral impairment or problem in accord with competent professional recommendation.
Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem which any reasonable layman would have recognized as needing professional psychological attention (e.g., severe depression, suicide attempt).
Other Emotional Neglect	Other inattention to the child's developmental/emotional needs not classifiable under any of the above forms of emotional neglect (e.g., markedly overprotective restrictions which foster immaturity or emotional overdependence, chronically applying expectations clearly inappropriate in relation to the child's age or level of development, etc.)

Educational Neglect

Permitted Chronic Truancy	Habitual truancy averaging at least 5 days a month was classifiable under this form of maltreatment if the parent/guardian had been informed of the problem and had not attempted to intervene.
Failure to Enroll/Other Truancy	Failure to register or enroll a child of mandatory school age, causing the school-aged child to remain at home for nonlegitimate reasons (e.g., to work, to care for siblings, etc.) an average of at least 3 days a month.
Inattention to Special Education Need	Refusal to allow or failure to obtain recommended remedial educational services, or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder or other special education need without reasonable cause.

According to the 1988 NIS-2 study,[13] almost 43 percent of the identified neglect was physical neglect, which included children living in unsafe housing, not being fed nutritionally adequate meals, being consistently without adequate clothing, and receiving grossly inadequate care for personal hygiene. The second largest category of neglect was inadequate supervision of children (36.6 percent) and failure or delay in providing health care (20.8 percent).

Large numbers of very young children are left without supervision or left in the care of only slightly older children who lack the judgment and maturity to safely provide for the infants and very young children. One study indicated that 22 percent of all first-time reports to New York's central child abuse registry during 1982–83 contained allegations of lack of supervision.[14] Often, children are left in this dangerous situation while their parents work or attend to other business. This category of neglect is difficult to define. At what

age may a child be left unattended, and for what period of time? At what age is a child competent to care for a younger sibling? Much depends upon the safety of the environment and the child's level of maturity and intelligence. These criteria are highly subjective and vary significantly among ethnic and subcultural groups. Young school-aged children in Oriental, Hispanic, and low-income African-American families are often expected to care for very young siblings in the absence of parents. Yet, studies have indicated a relatively high rate of injuries to children and child fatalities due to this type of neglect. [15]

Thus, there are many types of child neglect and an array of contributing factors. Abandonment of the child may stem from parental alcoholism, drug abuse, or despair. Inattention to dangerous, avoidable hazards in the home, such as unprotected heaters or fireplaces, may stem from lack of knowledge, poverty, and/or apathy. A significant delay in obtaining medical treatment for serious, acute, or chronic illness or accidental injury may be the result of lack of knowledge, lack of transportation, prohibitive cost, or other barriers to seeking medical services. Sexual abuse may be the result of a parent's failure to provide adequate supervision of a young child. Alcohol and drug abuse is a factor in a rapidly increasing percentage of child neglect cases, with estimates now running as high as 70 percent in some urban areas. Some parents meet the minimal physical needs of their children, but ignore their need for critical emotional nurturance.

WITHHOLDING OF MEDICALLY INDICATED TREATMENT FROM NEWBORN INFANTS

The withholding of medically indicated treatment from newborn infants with serious birth defects that are life-threatening is a category of neglect that was defined in the amended Child Abuse Prevention and Treatment Act of 1984 (P.L. 98–4576). These situations have been referred to as "Baby-Doe" cases, after a 1982 Indiana court case contesting the parents' rights to withhold medical treatment, food, and water from an infant who was born with a life-threatening but surgically correctable condition that prevented oral feeding.

The 1984 amendments to the Child Abuse Prevention and Treatment Act defined as neglectful: "The failure to provide treatment (including appropriate nutrition, hydration or medication) which, in the judgment of the physician would be most likely to be effective in ameliorating or correcting the life-threatening condition." The law and the regulations issued by the Department of Health and Human Services require that States receiving Federal funds for CPS programs regard the withholding of medically indicated treatment from these disabled infants with life-threatening conditions as a form of neglect and to actively investigate reported cases. Hospitals are likewise obligated to observe the provisions of the law and to post notices in newborn wards that failure to feed and provide care for disabled infants is a violation of Federal law.

The law does make exception for withholding treatment (other than nutrition, hydration, or medication) to an infant when, in the physician's reasonable medical judgment:

- The infant is chronically and irreversibly comatose.
- The provision of such treatment would merely prolong dying, be ineffective in correcting the life-threatening condition, or be futile in terms of the survival of the infant.
- The treatment would be virtually futile in terms of the survival of the infant and the treatment itself would in such a situation be inhumane. Food and water must *always* be provided regardless of the extent of disabilities, and "quality of life" cannot be used as a criterion for deciding upon appropriate medical treatment.[16]

Decisions about minimally adequate care for these infants present difficult moral and ethical dilemmas for physicians, hospital personnel, and parents of infants born with severely disabling mental and physical handicaps.

PRENATAL EXPOSURE TO DRUGS

Considerable controversy surrounds the issue of prenatal exposure of infants to drugs and alcohol. Courts are still debating whether such exposure is neglectful behavior on the part of a pregnant woman. Pregnant women who abuse alcohol, however, have exposed their fetuses to the serious mental and physical disabilities known as fetal alcohol syndrome. An estimated 73 percent of pregnant 12–34-year-old women have used alcohol sometime during their pregnancy. The incidence of fetal alcohol syndrome is 1.9 births per 1,000.[17] Prenatal exposure to cocaine and other drugs also results in negative developmental consequences for 30–40 percent of the estimated 500,000–740,000 drug-exposed infants in the United States.[18]

FAILURE TO THRIVE/MALNUTRITION

Children whose physical development falls below the third percentile in height and or weight for no known medical reason have been designated "nonorganic failure to thrive." Recent thinking calls for categorizing all children whose development is thus significantly impeded by inadequate nutritional intake as "acutely malnourished."[19] The parents' failure to provide necessary nutritional and/or emotional nurturing, often in spite of efforts to do so, presents a challenging problem which has proven difficult to remedy beyond immediate improvements with hospitalization. Failure to thrive children respond with improved weight gain and developmental progress to inpatient hospital treatment, which includes intensive enhancement of nutritional and emotional nurturing. Normal developmental progress frequently does not continue when the children are returned home to the care of parents, and followup studies indicate continuing developmental delays in about half of the children. Outcomes of intervention appear to be related to the cause of failure to thrive and the parents' degree of awareness and cooperation with the treatment. The less chronic the developmental failure and the greater awareness and cooperation of parents, the more positive the outcomes.[20]

Deficits in the critical bonding and attachment process between parent and child are thought to be at least partially responsible for the significant developmental delays among children. Depression and other personality problems in the parents, lack of knowledge about child care, poverty, and other sources of social stress have been identified as contributing causes of nonorganic failure to thrive. [21]

CHRONIC VS. "NEW" NEGLECT

Recent studies have revealed significant differences in the characteristics and problems of chronically neglectful families and "new" neglectful families.[22] Chronically neglecting families had more and older children, were poorer, had more problems, and less parenting knowledge than the newly neglecting families. Newly neglecting families had higher levels of stress, especially from recent serious illness or injury, and drugs were more likely to be a problem in their communities than for the chronically neglecting families.

The distinction between chronic and "new" cases of neglect may not hold up over time, however. "New" cases may actually represent the initial phase (stage) of chronic neglect. Whether this is so requires further research on the outcomes of "new" neglectful families.

To summarize, the definition of child neglect is problematic because of the lack of consensus on what is considered "minimally adequate" care of children. Although there is general agreement among professionals and the general public on what is clearly inadequate care, there are differences among professionals and

ethnic groups on minimally acceptable levels of physical, psychological, and educational care and nurturing for children of different ages. Conceptual definitions of neglect differ depending upon the purpose for which they are used. Clear evidence of specific harm to a child is needed in legal proceedings for removal of a child from a parent's custody. Protective services intervention to remedy parental omissions and prevent placements may use definitions of neglect that focus on parental skills deficits and the risk of harm to a child. There are newly debated areas of neglect that present difficult moral-ethical dilemmas, for example, prenatal exposure to drugs *in utero*. Research studies on neglect suggest that it is important for the child protection practitioner, policy maker, and the researcher to clearly differentiate among the specific types of neglect being considered.

UNDERSTANDING THE CAUSES OF NEGLECT

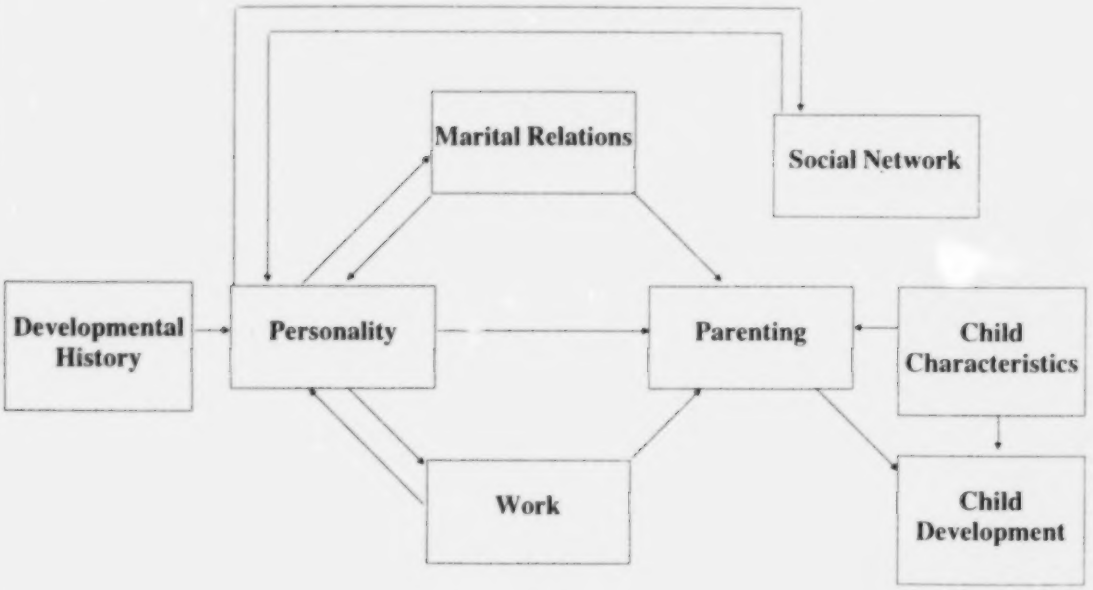
Effective intervention to prevent or remedy child neglect requires an understanding of the causes. However, specification of the causes of neglect is hampered by the limited research on child neglect. Most studies of child maltreatment include both neglectful and abusive families and fail to differentiate between the groups, thus making it impossible to identify results specifically related to neglect. The numbers of studies that focus specifically on child neglect are few in comparison to studies on other types of maltreatment. Studies are most often based on small, selected samples of reported and verified neglect, composed almost exclusively of very low-income families. For these reasons, the information about causes of neglect is limited and must be considered as only suggested by the existing research.

Nevertheless, it is clear from existing studies and from the experience of practitioners that there is no single cause of the inadequate parenting we term child neglect. Thus, understanding the causality of child neglect requires that it be viewed from a broad ecological-systems perspective. Building on the previous work of child development experts, Urie Bronfenbrenner, James Garbarino, and others, Belsksy has proposed that the causes of child maltreatment be considered in such an ecological framework.[23] Belsky and Vondra[24] have proposed that the determinants of adequate parenting arise from three sources:

- parents' own developmental history and resultant personal psychological resources,
- characteristics of the family and child, and
- contextual sources of stress and support.

Belsky and Vondra suggest that these factors interact to influence parenting as illustrated in Figure 1. The model illustrates that the sources of influence on parenting are interactive and often reciprocal. The developmental experiences of parents influence their personality and psychological resources, which directly influence both their parenting attitudes and behavior and their ability to develop supportive relationships with others. Parenting behavior influences the child's personality and behavior, which reciprocally influences parents' response to the child. The social context of the parent–child relationship, which includes the marital relationship, social network supports, and work-related factors, is highly influential on parenting. The model provides an organizing framework for examining the contributing causes of neglect suggested by the existing research.

Figure 1. Determinants of Parenting



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PARENTS' DEVELOPMENTAL HISTORY AND PERSONALITY FACTORS

The ability of a parent to provide adequate care for a child depends partly on his/her emotional maturity, coping skills, knowledge about children, mental capacity, and parenting skills.

Belsky and Vondra review evidence from numerous studies that provide support for the conclusion that "at least under certain stressful conditions, developmental history influences psychological well-being, which in turn affects parental functioning and, as a result, child development." [25]

These authors cite, among others, the Berkeley Growth Study, which provided data to support the linkages between personality, parenting, and then to child development. Growing up in unstable, hostile, nonnurturing homes led to unstable personalities when the children became adults, which led to stressful marriages and abusive parenting practices with their own children. Belsky and Vondra conclude from their review of relevant research that parental personality is the most influential factor on parenting because the personal psychological resources of the individual are also influential in determining the marital partner, the quality of the marital relationship, and the amount of social support one receives.

Child development researchers have used attachment theory to shed light on the personality development of abusive and neglectful mothers. Egeland and colleagues have concluded from their longitudinal study of high-risk mothers and children that the mothers' lack of secure psychological attachment and psychological immaturity result from inadequate care received as children. They found that regardless of level of stress or the availability of emotional supports for parenting, the emotional stability of the mother was the most

significant predictor of maltreatment. Mothers who were no longer maltreating their children at a 6-year followup were "more outgoing, more mature and less reactive to their feelings, more realistic in problem solving" than those who continued to neglect and abuse.[26] Others have also concluded that anxious or insecure emotional attachment between children and their parents results from interactions with parents who are physically or emotionally inaccessible, unresponsive, or inappropriately responsive to their children.[27] The conclusion of these studies is that it is not so much the inadequate or abusive nurturing experienced as children, but the unacknowledged deprivations and unresolved feelings around these early experiences that leave the parents unable to offer their children the consistent nurturing needed for the development of secure psychological attachments.

A cycle of neglect is suggested in numerous studies.[28] In Egeland et al.'s longitudinal study of maltreatment, only two out of the eight mothers who had been physically neglected as children were providing adequate care for their children. For the 35 mothers who had grown up in emotionally supportive homes, 20 were providing adequate care for their children; only 1 was maltreating her child.[29] Results of a study by Main and Goldwyn of 30 middle class women, not known to be abusive or neglectful, indicated that a mother's rejection by her own parents in childhood was strongly related to her own infant's avoidance of her following brief separations.[30] Over 56 percent of the 46 neglectful mothers in Polansky's study felt unwanted as children, and 41 percent had experienced some long-term out-of-home care as a child.[31] Nevertheless, the direct cause–effect relationship between parental history of neglect and subsequent neglect of children is not clearly established by the research. Most of the studies cited above are based on high risk or clinical samples or retrospective studies of identified neglectful parents who are not representative of the population of neglect victims.

Indeed, the indication is that there are important mediating factors in the transmission of neglect from one generation to the next. Victims of neglect who do not repeat the cycle have fewer stressful life events; stronger, more stable and supportive relationships with husbands or boyfriends; physically healthier babies; and fewer ambivalent feelings about their child's birth. They are also less likely to have been maltreated by both parents and more apt to have reported a supportive relationship with one parent or with another adult.[32] These mediating factors provide critical indicators for interventions improve parenting potential.

Polansky and colleagues identified distinguishing psychological characteristics of neglectful mothers, first among poor whites in rural areas of the South, then among poor whites in Philadelphia.[33] From the research with rural, Appalachian mothers, Polansky et al. identified five distinct types of neglectful mothers:

- impulse-ridden mothers,
- apathetic-futile mothers,
- mothers suffering from reactive depression,
- mentally retarded mothers, and
- psychotic mothers.[34]

The subsequent study in Philadelphia confirmed the first two classifications of neglectful mothers and identified character disorders, rather than neuroses or psychoses, as the predominant psychiatric diagnosis of neglectful mothers. Polansky and colleagues described the characteristic "modal personality" for neglectful mothers as:

> "Less able to love, less capable of working productively, less open about feelings, more prone to living planlessly and impulsively, but also susceptible to psychological symptoms and to phases of passive inactivity and numb fatalism." [35]

Polansky et al. referred to the personalities of neglectful parents as "infantile or narcissistic" to reflect their markedly immature personality development resulting from early emotional deprivation. Many neglectful mothers are indeed psychologically immature and childlike in their inabilities to consider the needs of others, postpone gratification of basic impulses, and to invest themselves emotionally in another person. Polansky and colleagues found impulsivity to be the personality characteristic that was most highly correlated with neglect among the low-income white mothers studied.[36]

This characteristic of neglectful mothers is corroborated by Friedrich, Tyler, and Clark's study of the personality characteristics of low-income, abusive, neglectful, and nonmaltreating control mothers.[37] The authors found that the neglectful mothers, when compared with the other two groups on standard psychological measures, were the most pathological of the three groups and were characterized as "the most hostile, most impulsive, under most stress, and the least socialized." [38] The neglectful mothers as a group were judged to be "more dysfunctional than the abusive mothers, less socialized, more angry, more impulsive, more easily aroused (by infant cries) and have greater difficulty habituating to stressful and nonstressful stimuli."[39]

Neglecting parents also score significantly higher on the rigidity, loneliness, unhappiness, and the negative concept of self and child dimensions of Milner's Child Abuse Potential Inventory. [40]

Depression

Although not consistently supported by research, clinical depression has also been associated with mothers who neglect. Studies of depressed women by psychiatric researchers have consistently found that depressed mothers are more likely than nondepressed mothers to be hostile, rejecting, and indifferent toward their children and to be neglectful especially with respect to feeding and supervision.[41]

Evidence for the association of depression and neglect from studies of neglect is mixed. Polansky's descriptions of neglectful mothers in Appalachia paint a picture of depressed women.[42] But only two controlled studies of neglectful mothers have specifically examined the relationship between depression and neglect. One study did not find a significant difference between small samples of neglectful, abusive, and normal mothers on a measure of psychopathology that included depression. [43]

Zuravin's more recent study of neglecting and nonneglecting AFDC mothers did find a significant relationship between depression and neglect.[44] Results of a controlled study of neglectful families currently in progress adds further support for the relationship between depression and neglect. Scores on a standardized measure of depression indicated that 60 percent of neglectful mothers versus only 33 percent of a comparison group of low-income nonneglecting mothers had a "clinically significant" problem with depression.[45] Further research is needed to firmly establish the relationship of clinical depression and neglect, but such a diagnosis should be considered when assessing child neglect and appropriate clinical treatment offered if indicated.

Poor Social Skills

As Polansky et al. suggest, neglectful parents are typically not only deficient in their parenting skills, but have pervasive deficiencies in coping skills in many areas of living.[46] The researchers' initial studies of neglectful mothers in Appalachia revealed that deficiencies in social skills and poor self-esteem resulted in

neglectful mothers selecting equally ineffectual, unsuccessful male partners, who only served to confirm and compound their deficiencies.[47] A subsequent study, which included neglectful fathers, revealed deficiencies in social participation and in their abilities to invest themselves emotionally in another person and in productive work.[48]

In Egeland et al.'s longitudinal mother–child study, the existence of an intact, long-term, stable relationship with a husband or boyfriend was found to be the critical factor distinguishing mothers who discontinued maltreating their children from those who continued to maltreat.[49] Belsky has suggested that the relationship between mother and spouse or boyfriend is the most critical supportive linkage for parents.[50] The majority of neglectful mothers lack this critical support.

Neglectful mothers also have significant deficiencies in their social-communication and problem-solving skills.[51] Polansky has characterized neglectful mothers as "verbally inaccessible." They lack the ability to express their own feelings in words, and therefore, are not good candidates for traditional psychotherapy. He explains that they are psychologically detached or "split off" from their own feelings, and thus, are unable to recognize feelings and put them into words.[52]

Neglectful parents have also been found to lack knowledge of and empathy for children's age-appropriate needs.[53] They have more unrealistic and more negative expectations of their children than nonneglecting parents.[54]

Substance Abuse

Abuse of alcohol or drugs is often present in cases of child neglect. Recent reports from urban CPS agencies indicate that substance abuse is a factor in a growing percentage of child neglect cases. Estimates range from a low of less than 24 percent[55] to 80 to 90 percent of all child maltreatment reports.[56] An earlier study found that 52 percent of the children removed from their homes for severe child abuse or neglect had at least one parent with a history of alcoholism.[57] A study of women served in a Chicago alcoholism treatment program reported that 65 to 75 percent of the women were neglectful toward their children.[58] The epidemic of cocaine addiction in urban inner-city areas has resulted in large increases in the numbers of neglect reports. The alarming increase of cocaine-affected infants has placed large burdens on the already overtaxed child welfare system.[59] In spite of these associations, there is yet insufficient data to conclude that substance abuse causes neglect, but it is an increasingly significant contributing factor.

CHARACTERISTICS OF CHILDREN AND FAMILY SYSTEM FACTORS

Research suggests that certain factors in family composition, size, and patterns of interaction contribute to child neglect. Even some characteristics of children may contribute to neglectful parenting.

Child Characteristics

Studies have not identified unique characteristics of neglected children that contribute to neglect. However, Crittenden's studies of parent–child interactions in abusive and neglectful families suggest that the children in neglectful families develop behavior patterns as a result of the interactions that make them more likely to experience further neglect.[60] As a result of the mother's inattention, the neglected child often develops patterns of either extremely passive, withdrawing behavior or random, undisciplined activity. Both of these patterns are likely to result in further inattention and distancing on the part of the child's neglectful parent. Studies have not clearly established the relationship between handicapped children and neglect. However, Belsky and Vondra cite numerous studies that support the association of prematurity, "difficult" temperament,

and mentally handicapped children with tendencies of their parents to be less responsive, less attentive to their needs.[61] Younger children are more vulnerable to serious injury from neglect, but when educational neglect is included, older children are more often neglected.[62]

Family Composition

Most neglectful families are single-parent families. The absence of the father in the majority of neglectful families means lower income and less tangible resources to provide for children's needs. Polansky, Chalmers, Buttenweiser, and Williams found that neglectful families with fathers present in the household had significantly higher income and provided better physical care than the single-parent families, but not better emotional/cognitive care.[63] The physical absence or emotional disengagement of the father has been identified as contributing to deprived parenting in families of failure to thrive infants.[64] Beyond these studies, little research attention has been focused on fathers or adult males in neglectful families.

Family Size

Chronic neglectful families tend to be *large* families with fewer resources to meet basic needs than other families. Numerous studies have discovered that neglectful families on the average have more children than nonneglecting families. Studies of neglectful families by Polansky in Philadelphia and in Georgia found that neglectful families averaged 3.5 or more children, compared to significantly fewer children in similarly situated (low socioeconomic status [SES]) nonneglecting control families.[65] Similar patterns of larger than average number of children in neglectful families were discovered by Giovannoni and Billingsley and by Wolock and Horowitz.[66] The *Study of National Incidence and Prevalence of Child Abuse and Neglect* reported that the estimated rate of neglect among families with four or more children was almost double the rate among families with three or fewer children.[67]

Family Interaction Patterns

Patterns of verbal and nonverbal communication between neglectful parents and children have been characterized as infrequent and predominantly negative. Burgess and Conger found that there were significantly fewer positive interactions and more negative interactions between neglectful parents and their children than in either abusive or in nonmaltreating families studied.[68] These researchers found that, compared with abusive mothers and nonmaltreating controls, the neglectful mothers stood out as the most negative and least positive in their relationships with other family members.

Crittenden similarly concluded that "neglecting mothers offered so little stimulation and responded to so few infant signals that they left their infants socially powerless and largely responsible for their own stimulation. Their infants showed correspondingly depressed levels of activity which reduced both the stimulations and feedback available to the already unresponsive mother. Mutual passivity was easily maintained."[69] This low level of positive interaction and stimulation between neglectful mothers and their children was confirmed by a series of studies by Crittenden and others.[70]

Crittenden describes distinctive patterns of interaction in neglecting, abusing and neglecting, and in marginally maltreating families observed in a small sample of these families.[71] The neglecting families in this study were largely young families with few children, with more than one adult caretaker, usually the maternal grandmother or mother's boyfriend. Parental coping strategies were withdrawal, deference to others whenever possible, or leaving tasks undone. Discipline was rarely used with the children. The parents' informal support networks were characterized by almost daily contact with relatives, who offered some tangible, but not emotional, support.

The neglecting parents are characterized by Crittenden as unresponsive and withdrawn: "They responded to few of their children's overtures when interacting with them and initiated almost no activity... Their children responded with a reduction in communicative activity."[72] Toddlers in the neglectful homes, as soon as they were able to walk, sought out their own stimulation through uncontrolled exploratory activity. Neglectful mothers largely ignored these "toddlers on the loose," only infrequently and ineffectively attempted to exercise some control by yelling at them, often without bothering to observe the results. The children merely imitated the parent's disregard.

Neglecting families who were also abusive were typically large, very unstable, and disorganized, with children sired by several different fathers. The mother had often lived with a series of men, been alone, and lived with her own mother for periods of time. "The only certainty was that the present structure, too, would change."[73] The parent–child interactions in these families vacillated from the extremes of nonsystematic, unpredictable, violent episodes of physical punishment in an effort to control the children's behavior to sullen withdrawal. The goal was momentary peace and quiet relief from the chaos in the family. Children react to their highly unpredictable environment by being always on guard and chronically anxious. The need to be ever vigilant to unpredictable violent adult reactions resulted in the children experiencing significant developmental delays.

The marginally maltreating families were typically two-parent families, but with different fathers for the children. The mother–partner relationships were unstable and often physically abusive. These families were disorganized and chaotic, constantly reacting to a series of day-to-day crises with frantic, ineffectual activity. There were no consistent rules or expectations of the children, and discipline was an expression of parents' frustration. The marginally maltreating parents were not able to engage in systematic problem solving, but instead stumbled from crisis to crisis trying to cope with whatever limited methods and help they could muster. These mothers were not always angry and could respond empathetically to their children's distress when it was expressed dramatically through tears or tantrums. Consequently, tears and tantrums were frequent, but the solace that resulted was short-lived and not secure.

These distinctively different patterns of interaction in contrasting types of neglecting families reinforce the need to assess each neglectful family independently. Individualized family patterns suggest the need for individualized interventions to remedy the neglect.

CONTEXTUAL SOURCES OF STRESS AND SUPPORT

Neglectful families do not exist in a vacuum. The availability of formal and informal supports for parenting from outside the family system are critical determinants of the adequacy of parenting. Schools, churches, work settings, neighborhoods, and communities can supplement parents' resources for providing adequate care for children. On the other hand, these systems can produce additional demands and stressors, which make parenting more difficult.

Unemployment, which causes psychological and economic stress, is frequent in neglectful families.[74] Neglectful families are less likely to be involved in church or other formal organizations that might be sources of tangible or psychological support. Neglectful families tend to live in impoverished neighborhoods and view their neighborhoods as less helpful and less supportive than do nonneglectful parents. Chronically neglecting families are viewed as deviant, even by their similarly impoverished neighbors, who avoid social contacts with them.[75] Families of color, who are overrepresented in child neglect statistics, must also cope with the stress of racial prejudice in many communities.

INFORMAL SUPPORT SYSTEMS

Most parents must rely at times on supportive relationships with spouses, other relatives, neighbors, and friends to cope with demanding parenting tasks, especially in times of illness, loss of income, or other life crises. Supportive linkages are particularly critical when the parent or child is handicapped by physical or emotional disabilities, or when there are many children to care for and few economic resources. Neglectful parents typically lack strong informal helping resources.[76] The social networks of neglectful mothers tend to be dominated by relatives who are critical, rather than supportive. Interactions with relatives may be frequent, but not very helpful. Because neglectful parents often lack the necessary social skills to maintain relationships, already weak linkages tend to break down, leaving the parents isolated and lonely.[77]

STRESS

The coping abilities of neglectful families are severely taxed by stressful life circumstances. As indicated above, the majority of neglectful families are poor, and not only poor, but usually the poorest of the poor. A high proportion of reported neglectful families are dependent upon public assistance for income, and they have the lowest income and the fewest material resources even among AFDC recipient families.[78]

Although chronic neglectful families are poorer and have more problems, the "new" neglectful families are under greater stress. For example, Nelson et al. found that 75 percent had experienced a serious illness or injury within the previous 3 years.[79]

People of color are overrepresented in neglectful families.[80] However, because of the higher incidence of poverty among Native Americans, Hispanics, and African-Americans, this overrepresentation seems to disappear when SES is held constant.[81] The ethnic and cultural differences in child maltreatment are small or nonexistent when families have adequate economic and social resources, but the combination of racial discrimination and poverty places unusual stresses on families of color that frequently overwhelm their coping resources.[82]

In summary, the causes of child neglect are multiple and complex. Most often neglect is the result of a combination of personal deficits in parents, conflictual, nonsupportive family systems and informal support networks, highly stressful life circumstances, and absence of environmental supports for parenting.

SHORT-AND LONG-TERM CONSEQUENCES OF NEGLECT

Child neglect can have devastating effects on the intellectual, physical, social, and psychological development of children. Numerous studies have documented significant developmental problems in children who have experienced inadequate, neglectful parenting. However, studies of maltreated children often fail to differentiate between abused and neglected children, or they are based on very small samples of neglected children. There is a lack of attention given to differentiating effects related to ethnic or racial differences. There are also important mediating factors that buffer the affects of neglect on its victims.

Drawing on attachment theory, child development researchers have accumulated substantial evidence that neglected and abused infants and toddlers fail to develop secure attachments with their neglecting and/or abusive primary care providers.[83] Because of the hostile, rejecting, inattentive, or inconsistent attention to their needs, these very young children receive, they develop anxious, insecure, or disorganized/disoriented attachments with their primary care providers. This lack of secure attachment relationship then hinders the infant's or toddler's ability to explore his/her environment and develop feelings of competence.[84] The effects of neglect and abuse on young children's socioemotional development have been demonstrated to be over and above the effects attributable to poverty. But there are important differences in the effects on preschool versus school-aged children. Detrimental effects are lessened when the parents enjoy and encourage their children and have access to supportive community resources.[85]

Social learning theory has also been employed to explain the differences that are found between abused and neglected children. Neglected children appear to be more generally passive and socially withdrawn in their interactions with peers, whereas abused children are more aggressive and active. Social learning theory suggests that neglected children's behavior is learned from the less active, socially withdrawn behavior that they observe modeled by their parents. Similarly, the abused children learn to imitate the more aggressive behavior of their parents.[86]

INFANTS AND TODDLERS

Limited research evidence from studies of small samples of neglected infants and toddlers reveals that children who are victims of physical and emotional neglect suffer severe and continuing problems in functioning. These studies suggest that the failure to develop secure attachments with primary caregivers results in further developmental problems. Egeland and colleagues' longitudinal Mother–Child Interaction Study revealed significant developmental deficits in neglected preschool children. Behavior that indicates infants' lack of secure psychological attachment to their mothers began to manifest itself at 12 months of age and got progressively more prevalent through the preschool years.[87] Two-year-olds demonstrated significant deficits in coping skills, more frustration, anger, and noncompliance when compared to nonneglected children in control groups. Neglected preschool children also manifested lower self-esteem, poorer control over impulses, and expressed less positive and more negative affect than the nonmaltreated children. When placed in an experimental Barrier–Box situation, where desirable toys were placed in a locked plexiglass box that prevented access to the toys, the neglected children were the least creative in seeking solutions to the dilemma. They were distractible and hyperactive, reluctant to seek help, and showed the most negative and least positive affect of the children. They were also the least persistent in problem solving.

At 42 months of age, the physically neglected children lacked persistence and enthusiasm and were negative and noncompliant in response to their mothers' efforts to teach them simple tasks. In a preschool classroom, these children were seen as more dependent and less able to control impulses than the nonmaltreated children. Children whose parents were emotionally neglectful manifested sharp declines on appropriate indicators of development from infancy through the toddler period.[88]

Observations of peer interactions among a group of 14- to 61-month-old children that included a very small sample of four neglected children, suggest that neglected children, when compared with nonmaltreated children, exhibit less positive and less negative affect, initiate fewer interactions and fewer positive behaviors toward others, and engage in less complex play with peers. Group interventions to improve peer interactions were effective with abused but not with the neglected children.[89]

KINDERGARTEN AND EARLY SCHOOL YEARS

As neglected children grow older, developmental deficits are still apparent. They are less well-prepared for learning. One study indicated that maltreated (mostly neglected) preschool and early school-aged children, when compared to nonmaltreated children from AFDC-recipient families, were less secure in their readiness to learn. The conclusion was that maltreated preschool and early school-aged children are less securely ready to learn in the company of novel adults.[90]

Teachers have rated neglected children as "extremely inattentive, uninvolved, reliant, lacking in creative initiative, and as having much difficulty in comprehending day-to-day schoolwork."[91] They were described as lacking "persistence, initiative and confidence to work on their own... They were dependent on the teacher—somewhat helpless, passive and withdrawn, and at times angry."[92] Egeland et al.'s study concluded that physically neglected children suffered the most severe developmental consequences of the four maltreated groups of children studied—neglected, physically abused, sexually abused children, and children whose parents were psychologically unavailable.

OLDER SCHOOL-AGED CHILDREN

School-aged children with histories of neglect have serious learning deficits. They score significantly lower on measures of school performance than physically abused or nonmaltreated children, particularly in the areas of reading and math.[93] Lack of intellectual stimulation in the neglectful home environment appears to result in significant language deficits.[94] Teachers report that neglected children work at below average levels and learn at below average levels. They also rate neglected children as having more behavioral problems in school than nonmaltreated children. Neglected children are absent from school significantly more often and have a higher percentage of grade repeats than nonmaltreated children.[95]

One study of maltreated children revealed that the maltreated 6–9-year-old children but not 4–5-year-olds were rated by their mothers as having significantly more behavioral problems, especially symptoms of depression and social withdrawal than nonmaltreated children from lower income families.[96] However, neglected children were not differentiated from abused children. Further research is needed to specify developmental effects for children by type of maltreatment and by age.

ADOLESCENTS

Juvenile delinquency is frequently associated with child abuse and neglect. Research findings are complicated because of weak research designs and inconsistencies in the definitions of delinquent acts and child

abuse and neglect. Yet, there is evidence of a high incidence of abuse and neglect among delinquent populations and a high incidence of delinquency among maltreated adolescents.

Retrospective studies of delinquents have reported rates of abuse and neglect that vary from 9 to over 60 percent, depending on the source of the information. Self-reports of prior abuse and neglect among delinquents run as high as 51 percent.[97] A study of 5,136 children in 1,423 families reported for child maltreatment in New York revealed that 42 percent of the families subsequently had at least 1 child taken to court for delinquent or ungovernable behavior.[98] This rate was five times greater than the rate in the general population of families in the counties studied. A recent prospective study by Widom did not differentiate neglected from abused children, but revealed that 29 percent of the subjects who were abused and neglected as children had an adult criminal record, compared to 21 percent of the nonmaltreated controls.[99]

Most often in research, neglect is not distinguished from abuse, and the causal sequence between child maltreatment and delinquent behavior is not clear.[100] There are also significant variables that mediate the relationship between maltreatment and delinquency. Widom's recent study would indicate that race, age, sex, identified behavior problems in mother's employment, and father's alcoholism all can increase or reduce the chances of criminal arrest for a maltreated child.[101]

MEDIATING EFFECTS

Negative developmental consequences for neglected children are not inevitable. Other factors have been identified, which either buffer or add to the effects of neglect on children. Stability of the children's living environment has been identified as modifying the negative effects of maltreatment, whereas multiple out-of-home placements, multiple life stresses, and parental depression contribute to more negative developmental effects of neglect and abuse on children.[102] Children with higher I.Q.'s also appear to suffer less serious developmental effects.[103]

NEGLECT-RELATED CHILD FATALITIES

Studies of child fatalities related to child maltreatment indicate that children die from neglect almost as often as from physical abuse. A review of 556 child fatality cases reported to CPS agencies in 1986 indicated that 44.3 percent were related to physical neglect.[104]

Margolin's study of 82 fatalities over an 8-year period revealed that 34 (40 percent) were from neglect.[105] The typical neglect fatality was a male child (male children were twice as likely as females to die) under age 3, living with a single mother and two or three siblings. The child typically died because a caregiver was not there at a critical moment. The fatal neglect was most often a preventable accident associated with a single, life-threatening incident. In 39 percent of the cases, the neglectful families were previously known to CPS agencies. Margolin discovered that several items from Polanksy's Childhood Level of Living Scale were significantly correlated with fatal child neglect. These items concerned exercise of judgment about leaving children alone.[106]

Alfaro's review of nine child fatality studies also concluded that fatalities from neglect were almost as frequent as from abuse.[107] Neglect was identified as contributing to the child's death in from 25 percent to 70 percent of the cases. Although many of Alfaro's findings were consistent with those of Margolin, the neglect-related fatalities were most often from two-parent homes. The victims were most often males, under age 2, and often the youngest or only child in the family. Alfaro concluded that fatal child neglect is difficult to predict and prevent. Reliable predictors do not exist, and in 70 percent of the cases, the families had not been previously reported for child abuse or neglect.[108]

To summarize, the indications from limited research are that child victims of neglect fail to develop secure psychological attachments as infants, and this seriously handicaps their subsequent development. Neglected preschool children demonstrate lack of readiness for learning, behavior problems, and less active interaction with peers. School-aged neglected children do poorly in school, but the connection between delinquency and abuse is less clear. Neglected children under age 3 are at high risk for child fatalities. However, children who have higher I.Q.'s and/or who live in less stressful, stable home environments suffer less serious effects of neglect.

ASSESSMENT OF NEGLECT

Effective intervention to prevent or remedy child neglect is dependent on accurate and continuing assessment. Assessment is an ongoing process that begins with the first contact and continues throughout the life of a case. To gain an understanding of the causes of neglect in a family, the assessment should include consideration of the areas outlined in Figure 2.

Figure 2. Assessment of Neglect

Type of Neglect
- Specific Indicators of Neglect
- Chronicity

Problems
- Identified by Referral Source
- Identified by Parent
- Identified by Helper

Factors Affecting Provision of Adequate Care
- Individual Personality
  - -strengths
  - -mental status/intelligence
  - -parenting knowledge and skills
  - -interpersonal skills
  - -physical health
  - -cooperation, motivation
- Family System
  - -strengths
  - -family size and composition
  - -income
  - -marital relationship
  - -special needs of children
  - -stability of family composition/membership
  - -structure, organization
  - -communication/interaction patterns
  - -family boundaries

Environmental/Community Stressors and Resources
- -housing
- -job/employment
- -neighborhood
- -informal social networks
- -cultural factors
- -availability and responsiveness of formally organized services

Setting Priorities

Structured Assessment Measures

INDICATORS OF NEGLECT

The assessment process begins with identification of the indicators of neglect; that is, the specific parental inadequacies resulting in the unmet basic needs of the child. For example, a toddler left unsupervised outside daily for an hour or more at a time; severely unsanitary or dangerous conditions in the home; failure to keep medical appointments for a child's serious health problem; nonorganic failure to thrive; or, chronic, unexplained absences from school are specific indicators of neglect. It is also important to determine whether the condition is chronic or a recent change.

Helping professionals must always remember that neglect means lack of *minimally* adequate care and be aware of cultural and social class differences and norms affecting child care. For example, the minimum age at which a child is expected to be able to care for a toddler varies among Hispanics, lower income African-Americans, and middle class whites. Older children in these families are trained to care for younger siblings and have learned basic safety skills, including who to contact in emergency situations. Child care and supervision is a responsibility shared by extended family members, neighbors, or friends in lower income African-American, Native American, and Hispanic families. Assessment of adequacy of supervision in these families must include these substitute or supplemental care providers.[109]

Similarly, assessment of the adequacy of the size, structure, and physical condition of housing and household furniture and appliances must be considered in the context of the limited housing options that conditions of poverty allow many families of color. The unavailability of adequate low-rent housing becomes a question of community neglect, rather than child neglect on the part of parents who are denied access to more adequate housing by reason of economics or discrimination.

PROBLEMS IDENTIFIED BY THE PARENTS

Obtaining the parent's own perspectives on the family's problems and their causes is essential. Parents' perceptions of problems and priorities may be quite different from that of professional helpers. Chronically neglectful families are typically poor, with multiple problems. Therefore, it is important to identify and set priorities among the family's neglect-related problems. A mother's concern about money to keep utilities on or to forestall eviction must come before the caseworker's concerns about teaching nonabusive approaches to disciplining children.

Gaining the cooperation of neglectful parents is often difficult, but necessary for effective intervention.[110] Recognizing and giving attention and assistance to the problems identified by the parents are critical to obtaining parental cooperation and commitment to improved parenting.[111]

CAUSES/BARRIERS TO PROVISION OF ADEQUATE CARE

To change a pattern of neglect, the helping professional must address the causes rather than the symptoms. For example, if an infant is malnourished due to parent neglect, CPS intervention would be very different for a mother who lacked knowledge about how and what to feed her baby than for a mother whose abuse of alcohol resulted in the baby's malnourishment.

Assessments should include examination of problems, causes, and barriers at all system levels, that is, individual, family, organizational/community, and cultural. It is equally important to identify and acknowledge the strengths, coping skills, and resources of parents and other family members that may be mobilized to reduce the risk of further maltreatment. The availability and accessibility of informal social network supports and formally organized supportive services should also be considered in the assessment.[112]

Understanding the interaction of stressful life circumstances, lack of environmental supports, and deficits in personal resources is the first step in developing a plan for intervention. The following factors should be considered in that assessment:

Individual Personality Factors

- Strengths, e.g., motivation, concern for the children, willingness to learn, and resourcefulness.
- Mental Status (while examples represent deficits, opposite assessment findings should be noted as strengths in mental status).
  - Diagnosis of serious mental illness or hospitalizations for mental illness.
  - Impaired intelligence level, e.g., evidence of mental disability or illiteracy.
  - Poor reality orientation, e.g., noticeable distortions of reality, disorientation to time, place, or circumstances.
  - Inappropriateness of affect, e.g., unusual elation or unhappiness.
  - Symptoms of depression, e.g., previous hospitalization for depression, loss of appetite, unexplained weight loss, restricted affect, listlessness, sleep disturbances, suicidal thoughts, poor self concept, or low self-esteem.
  - Poor judgment, especially in relation to care of children, use of money, etc.
  - Poor impulse control, e.g., difficulty in handling anger and controlling sexual urges, misspending money.
  - Substance abuse, e.g., abuse of alcohol or other drugs or addictions.
  - Overstressed, e.g., overwhelming feelings of helplessness, fears, and confusion resulting from a crisis with the report of neglect often exacerbating the stress.
- Parenting knowledge and skills, e.g., age-appropriate expectations of children, empathic ability with children, knowledge of children's medical needs, or safety consciousness.
- Interpersonal skills, e.g., verbal and written communication, ability to maintain social relationships, stability of intimate relationships, handling of conflict, and problem-solving skills.
- Physical health.
- Cooperation, motivation for accepting help, improving adequacy of parenting, and willingness to engage in a helping relationship.

Family System Factors

- Family strengths, e.g., concern for children, stable relationships, family cohesion, and assertiveness in problem-solving.
- Income, e.g., employment of head of household and adequacy of income.
- Size of household, number and spacing of children, and other dependent adults in home.
- Stability and supportiveness of marital relationship or relationship with significant intimate partner.
- Children with special needs, e.g., a physical or mental disability, serious behavioral problems, developmental delays, or learning problems.
- Stability of family membership, e.g., recent deaths, divorces, separations, births, children removed or replaced, or assuming care for children of relatives or friends.
- Degree of structure and organization of family, e.g., explicitness of family rules, discipline, roles, generational boundaries, and role reversals.
- Family interaction patterns, e.g., observed verbal and nonverbal communication between parents and children and between adults, attention to children, handling of conflict, balance of negative versus positive parent–child communications, amount of positive physical contact between parental figures and children, children's display of aggressive or withdrawing behaviors.
- Family boundaries, e.g., openness of the family to outside influences; amount of interaction across family boundaries with individuals, organizations, and the community; and knowledge of and use of formal and informal helping resources in community.

Environmental/Community Factors

- Housing, e.g., adequacy of space for family size; condition of housing; safe conditions for children; and availability of stable, affordable housing.
- Neighborhood supports for parenting, e.g., safety of neighborhood and recreational facilities; safety of play areas for children; level of neighborhood organization; and communicative, mutually supportive networks.
- Supportiveness of informal social networks, e.g., availability of relatives, neighbors, friends, pastors, etc. to provide tangible aid, advice, guidance, and emotional support to assist parents.
- Availability of organized parenting support services, e.g., availability of affordable child care, emergency assistance, after-school programs, recreational programs, parks, high-quality school programs for children with special needs, mental health, and health care, family counseling, parent education, and peer support groups.

Cultural Factors

- Cultural strengths
  - Strong loyalty to "family," family cohesiveness and family ownership of children's problems in Native American, African-American, Hispanic, and Asian families.[113]
  - Strong, supportive extended family linkages and sharing in child care tasks by family, friends, and neighbors in families of color.[114]
  - Cultural emphasis on discipline, obedience to rules, and respect for elders who are sources of advice for child rearing.
  - Bicultural competence of children and adults, which permits preserving cultural identity while negotiating the dominant culture.
  - The use of humor as a means of coping for African-Americans.
  - Cultural emphasis on independence of children in Native American families and interdependence of siblings in Hispanic families.
  - Strong religious values, customs, rituals, and institutions that provide spiritual support and reinforce strong, ethical values for life decisions, respect for elders, and give meaning to life. Churches provide group socialization activities and supplementary child care for children.
  - Value placed on education of children, who are seen as the hope for the future by African-Americans and Asians.[115]
  - Strong ethnic community representatives and organizations that help people of color to bargain, negotiate, and obtain resources from the larger societal systems.
- Cultural Barriers
  - Language differences between immigrant groups and larger culture. Use of "Black English" by some lower-SES African-Americans in larger white-oriented society.[116]
  - Differences in styles of communication, e.g., avoidance of eye contact with whites by Native Americans, African-Americans, and norms that prohibit sharing of strong feelings with nonfamily members by Asians and Hispanics.
  - Discrimination, bias by majority Anglo-whites against immigrant minorities or people of color.
  - Child-rearing norms that are at variance with dominant culture norms, e.g., use of folk remedies to treat illnesses or expecting young school-aged children to care for toddlers.
  - Social status differences and conflicts within Hispanic, Asian, African-American groups.

- Lack of knowledge about how the larger social systems operate in the dominant culture, i.e., how to cope with complex bureaucracies and political processes.

- Distrust of authority figures from majority culture or assumption of punishment rather than help.

- Resources to Overcome Obstacles

  - Crosscultural competence of professional helpers, who are informed about diverse cultural heritages, values, customs, child rearing norms and practices, communication styles, and aware of their own cultural heritage and biases.

  - Culturally sensitive and responsive outreach to people of color by organizations and communities.

A complete assessment of neglectful families includes consideration of all factors that may be contributing to the child's neglect as well as factors that may contribute to problem resolution. The diagnostic assessment and service/treatment plan is based on this information with revisions occurring as additional information about the family is obtained.

SETTING PRIORITIES

The professional helper works with the family to assign priorities in problem resolution, identifying the top two to five mutually agreed upon priorities for action. The priorities then become the first problems addressed in the service/treatment plan. For example, Goal #1—obtain immunizations for preschool child; Goal #2—obtain safe housing for family. Breaking goals down into manageable achievable subgoals helps neglectful families' problem solving, and achievement of small goals increases the family's motivation to improve.

STRUCTURED ASSESSMENT MEASURES

Structured assessment measures have been used in both research and intervention projects with neglectful families to learn about the characteristics of neglect; provide a clearly defined, limited focus for interventions; and provide a means for systematically assessing intervention outcomes.

Measures of Quality of Parenting

- Polanksy's Childhood Level of Living Scale (CLL) was developed to provide a quantifiable measure of the quality of physical and emotional/cognitive care for young children.[117] The scale consists of 99 items, which were selected as observable indicators of the quality of care to be used in discriminating between neglectful care and high-quality care of children. The responses to the items are a simple "yes/no" to each item, indicating the presence or absence of the behavior of the parent toward the child. The scale must be completed by a caseworker or someone else who is familiar with the parent's patterns of behavior toward the child for whom quality of care is being assessed. It yields a total score on a scale of 1–99, with higher scores indicating better quality of care. Scores can also be calculated separately for physical care, emotional/cognitive care, and nine subscales. Reliability and validity are well established, and norms have been empirically established for neglectful, severely neglectful, marginally adequate, adequate, and excellent levels of care.[118] A caseworker or volunteer familiar with the family can complete the scale in 15 minutes or less. It can be a useful tool for systematically assessing the quality of physical and emotional/cognitive care being provided by a parent and for measuring improvements in quality of care over time.[119]

- The Child Well-Being Scale is a more recently developed scale for measuring adequacy of child care.[120] The scale, like the CLL, is completed by a person familiar with the family's patterns of child care. Quality of child care is assessed on 43 separate dimensions, which range from provision of nutritious meals and physical safety of the home to the appropriateness of the parent or other care provider's expectations for the child. Each anchored scale proposes to measure a dimension of care related to one or more physical, psychological, or social needs of children. The assumption is that the degree to which these needs are met defines the status of the child's overall well-being. Three primary factors are measured—household adequacy, parental disposition, and child performance. The latter factor is assessed on the basis of anchored ratings on four of the subscales applied to each child in the family. The subscales assess educational status and performance and delinquent behavior and are thus applicable only to school-aged children. Recent application of this measure with neglectful families support its reliability and validity.[121]

- The HOME Inventory is a structured observation/interview instrument that assesses the quality of the child-rearing (home) environment.[122] Separate rating scales are available for infants (birth to age 1), toddlers (age 1–3), and 3–6 year olds. Items cover parental interactions and activities with the child to provide intellectual stimulation, the safety and quality of the physical home environment, and the discipline and emotional nurturing of the child. Many of the scale items assess the presence in the home of age-appropriate books and toys for the children that would be found most often in middle class homes. These items appear to bias the scale toward middle- and upper-income groups and indeed, the scale does correlate significantly with measures of SES.

- The CLEAN Checklist (Checklist for Living Environments to Assess Neglect) was created by Watson-Perczel to assess home cleanliness.[123] The checklist divides each room into "item areas" such as furnishings, surface areas, fixtures, and appliances. Each item area is inspected to determine whether the item area is clean or dirty, the number of clothes or linens in direct contact with an item area, and the number of items not belonging in contact with a particular area. The CLEAN produces a composite percentage score reflecting the condition of the home along three dimensions—clean/dirty, clothes/linens, and items not belonging.[124] This structured assessment measure enables the professional helper or volunteer to identify specific, measurable, and achievable goals for improving the cleanliness of the physical environment when this has been identified as less than adequate or neglectful. Program evaluation using single subject designs and feedback from CPS caseworkers indicates that the use of this instrument with a very structured, behavioral home cleanliness program resulted in lasting changes in the home conditions.[125]

- The Home Accident Prevention Inventory (HAPI) has been used similarly to assess the safety of the home environment and to provide a measure for assessing outcomes of behavioral interventions to remedy unsafe home conditions for children. The HAPI includes five categories of safety hazards in the home—fire and electrical, mechanical-suffocation, ingested object suffocation, firearms, and solid and liquid poisons. The measure was used to assess improvements in home safety resulting from a structured, behavioral intervention program. Neglectful families were provided detailed instructions for remedying the unsafe conditions and feedback regarding the number and location of the safety hazards in the home. Subsequent assessments of the hazardous categories in each home after the interventions indicated large decreases in seriously hazardous conditions over several months.[126]

Social Network Assessment Measures

A number of structured assessment instruments can be used to assess the quantity and quality of a family's linkages with formal and informal supportive resources outside the family system.

- The Eco-Map is one of the simplest and most widely used measures.[127] Information about the family members' relationships with agencies, employers, church, school, other organizations, relatives, friends, and neighbors is plotted on a one-page circular chart. The lines from family members to outside individuals and groups are drawn to indicate supportive or conflictual relationships. A graphic picture of the family's support system or lack of supports is illustrated. This can be used to identify problematic relationships that could be improved to become supportive or to identify the need for making new supportive relationships.

- The Social Network Map and Social Network Assessment Guide are examples of structured measures designed to assess the size, intensity, composition, and supportiveness of the parent's informal social network.[128] These measures yield a picture of the social network as perceived by the parent and provide direction for interventions to assist neglectful parents to increase the size, composition, and supportiveness of the network.

Observational Measures

Structured observational guides have also been used by researchers and practitioners to assess the quality of parent–child interactions in neglectful families and to assess outcomes of interventions to improve the quality of those interactions.[129]

- For use with parents of young children, Crittenden has developed the 52-item CARE-Index as an observational measure of the quality of parent–child interactions.[130] The measure focuses on seven aspects of dyadic parent–child behavior:

  - facial expression,
  - vocal expression,
  - position and body contact,
  - expression of affection,
  - pacing, and
  - control and choice of activity.

For each aspect of behavior, there are three items describing the quality of the adult care provider's behavior and four items describing the child's behavior. The scored items describing each quality are added up to provide three scale scores for adults, that is, "sensitivity, controllingness, and unresponsiveness," and four for children.[131] Parents and children are observed playing as naturally as possible in the home on a small blanket spread on the floor and in a "Strange Situation" laboratory setting. Observations may also be videotaped for coding and later comparison.

The use of the CARE-Index for research purposes requires structured situations and intensive training of observers to achieve acceptable levels of reliability. However, the measures do provide guidelines that can be used by professional helpers to aid in the assessment of specific parent–child behaviors that require modification to improve the quality of child care. For example, observation of the relative absence of physical holding, eye contact, or positive verbal messages by a parent indicates the need to teach nurturing behaviors, as appropriate to the parent's ethnic or cultural background.

Risk Assessment Measures

Over the past 10 years, public child welfare agencies have increasingly turned to structured risk assessment instruments in an effort to standardize assessment and decision making, set service priorities, manage the large numbers of referrals, and help identify family problems and strengths. The risk assessment instruments range from simple rating scales to highly complex rating systems, which yield weighted numerical scores for categorizing families by degree of assessed risk for future maltreatment.

Most of the risk assessment measures do not differentiate neglect from abuse. Alaska's risk assessment instrument is an exception. It yields a separate risk score for neglect and for physical abuse.[132] The neglect scale is designed to assess the likelihood for continued neglect for cases reported to an agency for child maltreatment. The factors were empirically determined through a study of 550 families referred for child maltreatment over a 12-month period. The nine factors selected to predict the likelihood of child neglect include:

- previous referrals for neglect,
- number of previous out-of-home placements,
- caretaker neglected as a child,
- single caretaker in home at time of referral,
- caretaker history of drug/alcohol abuse,
- age of youngest caretaker at time of referral,
- number of children in home,
- caretaker involved in primarily negative social relationships, and
- motivation for change on part of caretaker.

Weighted risk scores derived from the workers ratings on these nine factors have proved to be reliable predictors for subsequent neglect.[133]

Risk assessment rating scales are very useful for training new CPS caseworkers. The scales provide a framework for understanding and recognizing critical case factors. However, as Wald has pointed out, these rating scales, which are most often not based on empirical research, should not be used to replace clinical judgment by trained professionals about individual child neglect situations.[134] They can be used with an awareness of their limitations, as useful tools to guide and supplement clinical judgment, but never as rigidly applied criteria for decision making.[135]

Appropriate allowances must also be made for cultural differences on risk indicators. The State of Washington has developed a risk assessment matrix and checklist for family and community strengths and resources that provides guidelines for multicultural assessment.[136]

In summary, the assessment process in cases of child neglect requires several steps and sets the stage for subsequent intervention. The helping professional must be particularly sensitive to the need to involve the neglectful family in the process. Further, distinctions in cases must be made with regard to cultural norms and SES. Structured assessment measures are useful supplements to professional judgment about areas in need of remediation.

INTERVENTION

Appropriate intervention must be tailored to the type of neglect and the outcome of the assessment process. Intervention with a nonorganic failure to thrive child usually requires immediate hospitalization of the infant with intensive nutritional and emotional nurturing for 2 weeks and intensive coaching and instruction for the parents. Recent research indicates that "new," nonchronic neglect is characterized by high stress related to recent life crises.[137] In these cases, a crisis intervention model of family preservation may be the most appropriate course of action. Chronic, multiproblem neglectful families require more sustained intervention with multiple services. Neglectful families, who are also abusive, require more attention to behavioral approaches to anger control.

When neglect is primarily a result of individual and family factors, intervention is different than when it is a matter of environment or community conditions. Neglectful mothers who fit the Polansky typology of the apathy–futility syndrome[138] must be treated differently than those whose neglect is a result of recent unemployment or lack of parental support systems.

GENERAL GUIDELINES FOR INTERVENTION

- Most neglectful parents want to be good parents, but lack the personal, financial, and/or supportive resources. Professional helpers must assume that parents *want* to improve the quality of care for their children. Interventions must be developed with that assumption.

- All parents have strengths that can be mobilized. The hidden strengths of the neglectful parent must be identified during the assessment process, reinforced, and interventions planned to build upon those strengths. An act as simple as opening the door to the professional visiting the home suggests good will and positive intent.

- Helping interventions must be culturally sensitive. Professional helpers must intervene with knowledge of and respect for the differences in life experiences, cultural and religious beliefs, child-rearing norms, and role expectations held by families of color. Interventions should build upon the strengths of families of color. Helpers should, for example, make use of respected elders as role models and key resources, involve extended family members in child caring, respect and affirm religious/spiritual values and beliefs that support responsible parenting, and seek to involve males in child-caring tasks.[139]

- Each family is unique, regardless of ethnic or cultural background. Assumptions and generalizations about neglectful families lead to inappropriate intervention decisions. How the family perceives the professional helper, the CPS agency, and various forms of intervention must be determined on a case-by-case basis.

- Neglectful parents are typically psychologically immature, usually as a result of their own lack of nurturing as children. They require nurturing themselves to enable them to nurture their children adequately. They may have negative perceptions of themselves as parents and little confidence in their abilities to improve their parenting. Helping a neglectful parent to recall, acknowledge, and

express long-suppressed feelings about the parent's own experience of neglect or abuse as a child may enable the parent to avoid repeating the cycle.[140] Treatment goals must include building feelings of hope, self-esteem, and self-sufficiency.

- Intervention with neglectful parents requires that the helper "parent the parent" and "begin where the client is." The professional helper must listen empathetically and validate the concerns and feelings of family members, then support and encourage progressively more independent, responsible behavior.

- Fostering dysfunctional dependency must be avoided by maintaining a balance between supportive counseling, enabling the family to use supportive formal and informal services, and communicating expectations for achievement of realistic, achievable goals that represent progressively more independent, responsible functioning.

- It is essential to set clearly stated, limited, achievable goals that are shared with and agreed upon by the parents and children. Goals should emerge from the problems identified by the parents and the professional helper and from the causes or obstacles to remedying the problems. Goals should be clearly expressed in a written service/treatment plan, which is developed with the family. A limited goal may be for a chronically neglectful parent to secure hazardous materials in a cabinet out of children's reach or to keep a medical appointment.

- Neglectful parents are empowered when the professional helper systematically reinforces the parent's limited, incremental achievements with tangible rewards and praise. It is helpful to reward a parent's efforts to wash the dishes, make a positive statement about him/herself or his/her child, play with his/her child, prepare a hot meal, make a friend, or keep an appointment.

- The treatment/service plan should be clearly outlined, with responsibilities for parent and professional helpers clearly identified. The plan should be viewed as a *contract* between the neglecting family and the professional helper.

- The exercise of legal authority by the professional helper is often necessary to overcome the initial denial and apathy of the neglectful parent. Confrontation with the reality of legal mandates and the possibility of legal intervention are sometimes necessary to disturb the dysfunctional family balance and mobilize the parent to change neglectful parenting practices. Threat of legal action should be used only as a last resort after efforts to obtain cooperation have been tried.

- Neglectful families are typically poor and lack access to resources. Therefore, the intervention plan must include brokering and advocacy to mobilize concrete formal and informal helping resources. Case management of multiple services is necessary. Successful mobilization of outside resources to meet the family's identified priorities helps to overcome the family's hopelessness, resistance, and distrust of professional helpers.

Community services that may need to be mobilized for neglectful families include the following:

- emergency financial assistance,

- low-cost housing,

- emergency food bank,
- clothing bank,
- low-cost medical care,
- transportation,
- homemakers,
- parent aides,
- recreation programs,
- mental health assessment and treatment,
- temporary foster care or respite care,
- budget/credit counseling,
- job training and placement,
- parent support/skills training groups, and
- low-cost child care.

- Treatment of chronic neglect is not a short-term project. Successful intervention with neglectful parents should last for 12 to 18 months. When neglect is not a chronic pattern, shorter term, more intensive intervention may be successful.

INTERVENTIONS TO REMEDY NEGLECT

The extent of evaluative research on the effectiveness of interventions with neglectful families is small, but growing. The research gives some guidelines for more effective interventions with neglect, but overall results of evaluative research show limited success. Reviews of projects to remedy neglect indicate that with few exceptions, even the best conceived and funded intervention programs with neglectful families have had difficulty achieving desired case outcomes. Daro's review of 19 demonstration programs with neglectful families, funded by the National Center on Child Abuse and Neglect over the period 1978–1982, revealed that in only 53 percent of the neglectful families was there improvement in the families' overall level of functioning, and 70 percent were judged likely to recidivate after case closing. In 66 percent of the neglectful families, there were additional reports of neglect while intervention was in progress. Daro concluded that regardless of the type of intervention, the severity of the families' problems was the most powerful predictor of outcome. The presence of alcohol and drug problems consistently correlated with less successful outcomes.[141]

Nevertheless, some interventions proved more successful than others, and the reviews by Daro and others provide some helpful guidelines for more effective interventions with neglectful families.[142]

MULTISERVICE INTERVENTIONS

Because most neglectful families are multiproblem families with many deficits, no one intervention technique or method can be successful. Successful intervention requires the delivery of a broad range of concrete, supportive community services from multiple sources and a combination of individual, family, and group methods that include individual counseling, behavioral methods, individual and group parenting education, and family therapy.

Project 12-Ways is an example of such an approach.[143] The 12 different services offered to neglectful families included emergency financial assistance, transportation, homemakers, recreational opportunities, weight loss program, and parent groups as well as behavioral techniques for teaching parenting and home management skills. Followup reviews for up to 42 months after termination of services revealed that improvement in specific home management and child management skills endured.

The Family Support Center in Ogden, Utah, is another intensive, inhome, family-centered intervention model with multiple services designed for chronically neglectful families.[144] This program combines intensive, biweekly, in-home instruction on nutrition, home and money management, and child care skills from a trained parent aide; parent support groups; employment preparation; and facilitation of connections with community services. Outcomes of this project have not yet been published.

The Bowen Center project was an earlier example of a successful model that offered child care, intensive individual casework/counseling, homemakers, temporary shelter, recreation activities, and special education for older children as well as advocacy to obtain for parents a range of tangible supportive services.[145]

The Anchorage Center for Families is one of six NCCAN-funded 3-year demonstration projects targeting chronic child neglect.[146] This program provides a multiservice model that emphasizes coordinated parent involvement in planning and disposition of services; use of trained volunteers; home-based interventions; and attention to the educational, vocational, and social needs of parents as well as strengthening linkages between families and community. The outcomes from this project are not yet available.

Multidisciplinary teams can greatly facilitate the necessary coordination of therapeutic and supportive services provided by a variety of agencies and the legal interventions, when necessary, to assure the child's safety. Some States now mandate the establishment of multidisciplinary teams for handling child abuse and neglect that include representatives from child welfare, law enforcement, the courts, schools, hospitals, health departments, and mental health agencies and the development of written protocols for interdisciplinary coordination. Regularly scheduled meetings, skilled leadership, and ongoing problem solving is necessary for team building to make these efforts successful. The investment of time and effort pays off in more focused, effective intervention with neglectful families.

FAMILY-FOCUSED INTERVENTIONS

Daro concluded from her review of demonstration projects that interventions that included family members, rather than focusing only on the principal care provider, were more successful.[147] Although not definitive about the type of family intervention, she concluded that interventions must target the dysfunctional family system, not just the parent. Traditional, inoffice, one-to-one counseling by professionals is ineffective with neglect. This conclusion is consistent with systems theory regarding the resistance of systems to change, even if the balance is dysfunctional. In their Philadelphia study, Polansky et al. advised that assertive, intrusive intervention is necessary with neglectful families to disturb the dysfunctional family balance in the interest of achieving a more functional family system balance that does not sacrifice the needs of the children.[148] Some examples of such family interventions are those that seek to reallocate family role tasks,

establish clear intergenerational boundaries, clarify communication among family members, reframe parents dysfunctional perceptions of themselves and their children, and enable parents to assume a strong leadership role in the family.

The Nurturing Program is a time-limited parent education program that insists on the importance of the active involvement of both parents and children. [149] The rationale is that to change established patterns of abusive and neglectful parenting all family members must learn new ways of interacting. This cannot be accomplished unless the children, as well as the adults, are taught new ways of thinking and responding.

Project TIME for Parents was of the more successful treatment models reviewed by Daro that employed inhome family therapy along with behavioral interventions and financial incentives to assist neglectful families.[150]

FAMILY PRESERVATION SERVICES

Concern about the rapid growth of the number of children in out-of-home care has produced an increased emphasis on the use of intensive inhome, family-focused models of service. One prototype program is the Homebuilders model developed by Haapala and Kinney[151] in Washington State. This model of intensive, short-term, crisis intervention services is designed to improve family functioning to prevent out-of-home placement of children "at imminent risk of placement." It has demonstrated its effectiveness and has been replicated in many States.

Intensive family-centered family preservation programs developed the common commitments to:

- focusing services upon the entire family;
- providing a range of tangible, supportive, and therapeutic services;
- using short-term intervention of 6 months duration or less;
- establishing small caseloads; and
- using well trained, supervised, and supported caseworkers.

Nelson and Landsman have identified three categories of such programs.[152] The first category includes crisis intervention models similar to the Homebuilders program. Relying on crisis intervention, learning theory, and an ecological perspective, these programs provide a range of tangible, supportive, and therapeutic services with the caseworker available around the clock for a period of 30 to 45 days. Interventions rely heavily on behavioral methods for skills and self-management training. Caseworkers have a maximum caseload of three, which enables them to have daily contact with families. Evaluations of the Homebuilders model show up to a 92-percent success in preventing placements, but success rates vary depending on the setting and type of families served.[153] A study of five such programs in Maine indicated effectiveness with crisis cases and with those "in a chronic state of maladaptive behavior."[154]

A second type of family preservation model identified by Nelson et al. is the "Home-Based Model."[155] Family systems theory is the theoretical base, with some aspects of crisis intervention. The prototype model is the FAMILIES program of Iowa.[156] The interventions focus on the family system, family subsystems, and the family's relationships with the community. A wide range of concrete and supportive services is also provided for a period averaging 4-1/2 months. Caseloads average 10–12 cases per caseworker, supplemented with paraprofessional assistance.

The third type of family preservation program is the Family Treatment Model. Because this model is less intensive than the other two types, with less emphasis on concrete services, its application to neglect cases is more limited. The model emphasizes treating the family as a whole in a three-stage intervention process, that is, assessment, treatment, and termination. Services are offered in the home or office for 90 days by caseworkers with caseloads limited to 11. The Intensive Family Services (IFS) program in Oregon is the prototype for this family preservation model.

All of these family preservation program models offer promise with neglectful families. However, because of great variation in the populations served and methodological differences in outcome studies, it is not clear how effective the models are with chronically neglectful families. One recent study of family preservation services offered through eight demonstration projects in California revealed that such programs are less successful with chronically neglectful families than with families at risk of disruption because of other types of child maltreatment. Out-of-home placement occurred in spite of the services for 27 percent of the neglected families, but for only 11.7 percent of the children at risk of placement for other reasons.[157]

Yet, the overall success of family preservation programs in preventing placements of children and adolescents from dysfunctional families, many of whom are neglectful, is impressive. The comprehensiveness and intensity of the services is consistent with the needs of neglectful families. Particularly promising is the use of family preservation with nonchronic "new" neglectful families.

GROUP APPROACHES

The reviews of child abuse and neglect demonstration projects by both Daro and Cohn agree that projects that included group methods were more successful with abusing and neglecting families.[158] Participation in Parents Anonymous groups was found to be particularly effective, regardless of what other services were received by parents.[159] Groups for neglectful parents that provide very basic child care information and skills, problem solving, home management, and social interaction skills were more successful with neglectful parents than those offering more general content on child development and needs of children.[160]

The author's own Social Network Intervention Project with neglectful families affirmed that the use of parent support groups that combined problem solving, social skills enhancement, and teaching child behavior management skills contributed to successful outcomes.[161] Aderman and Russell report improvements in abusive and neglectful parents' care and nurturing of their children after their participation in 9-week groups that used techniques derived from constructivist approaches to work with families.[162] The therapists used metalevel circular questioning to challenge the premises underlying the families' dysfunctional patterns of interaction and to shift parents' focus from their perceived need to defend themselves to focus on the needs of their children.

Groups were the primary method used in the Oregon Self-Sufficiency Project to improve the functioning of chronically neglecting families.[163] Separate groups for parents, children, and teens followed by combined multiple family groups ran simultaneously one evening a week for 24 weeks. Because of the project's emphasis on "family empowerment," the initial parent group was largely unstructured and encouraged parent involvement in setting group agendas and activities. Experience dictated that more direction and structure was needed, at least initially, to facilitate active involvement of neglectful parents. Rather than serving as parenting classes to provide information, the groups were designed to provide encouragement and support for the families to develop their strengths, become involved in decisions about their lives, and provide mutual support. The group services were supplemented by a range of services that included inhome parent training, individual and family therapy, emergency assistance, crisis nursery, homemaker services, alcohol and drug treatment, public health, and mental health services. Families attended on average, only half of the 24 group sessions. Only 14 of 31 families served over 18 months showed significant improvements on self-report and

observational measures. Measured improvements were positively correlated with number of group sessions attended and hours of inhouse parent training from parent aides. Drug and alcohol problems were associated with negative outcomes.

Groups for neglectful parents should begin with the understanding that neglectful parents lack good social skills and are, therefore, ill-at-ease in groups. The following guidelines are suggested for conducting groups with neglectful parents.

- Group membership should be as homogeneous as possible by age, sex, race, and educational levels. Greater heterogeneity makes it more difficult to involve neglectful parents in a group and to achieve essential group cohesion. Keep group membership limited to 8–12 members and closed after the first few weeks. New members may be added if the group agrees by consensus.

- Meet with each parent before the group begins to get to know the parent; assess his/her intellectual level and interactional skills; clarify the group purpose, rules, and procedures; answer questions; anticipate barriers to group attendance; and relieve the parent's anxiety.

- Groups should be planned to last 3–6 months, meeting weekly for at least an hour, but no longer than 90 minutes. Clarify group rules in the initial sessions and gain consensus about the rules.

- Structured group activities are necessary, particularly in the beginning phases, to relieve anxiety and provide direction, but leaders must be willing to depart from planned agenda when concerns expressed by the group indicate the need. Parent group programs, such as The Nurturing Program, offer structured activities and games for parents and children that trained volunteers are able to conduct with professional supervision and consultation.[164]

- Refreshments are an important element. Food is a tangible way of nurturing the neglectful parent. It can also be a means of teaching good nutrition. After the group becomes more cohesive, members may be encouraged to bring favorite refreshments, if they desire.

- Provision of transportation and child care are essential supportive services. Simultaneous groups for the preschool and young school-aged children, if possible, are an effective way to meet the child care need and also greatly enhance the effectiveness of the groups. Bavolek's Nurturing Program recommends this approach, and it has been used effectively with neglectful parents and children.[165]

- Group leaders must be experienced in working with neglectful parents and have group leadership skills. Group leaders must have time to plan and organize groups. The assistance of trained volunteers or paid parent aides to assist with transportation, group activities, and child care is often necessary.

- Social activities, (e.g., outings to shopping centers, picnics, and trips to ball games) are very important for building a feeling of belonging, establishing group cohesion, and enhancing social skills.

Intensive, Problem-Focused Casework/Counseling Techniques

Daro's review indicated that intensive, weekly, inhome casework-counseling focusing on concrete problem solving is effective with neglectful families.[166] This conclusion was confirmed by the author's experience with the Social Network Intervention Project, by the earlier Bowen Center Project, and by the results of Lutzker and colleagues with Project 12-Ways.[167]

Structured intervention approaches that have clearly defined, short-range goals, and well-defined intervention activities are more successful than loosely defined "casework" or "counseling" interventions.[168] Contracting with neglectful parents for specific activities and goals to be achieved has been found to be helpful. Structured interventions offer clearly described, sequential steps and procedures to guide the professional or paraprofessional helper's efforts to assist families. The Nurturing Program and the Small Wonder infant stimulation exercises are two examples of structured programs.[169]

Behavioral Approaches/Social Skills Training

Lutzker and his colleagues employed a behavioral approach, which relied heavily on intensive, weekly or more frequent inhome interventions that broke down the problems of poor hygiene, unsafe home conditions, and child management into manageable units. Parents and children were taught specific behavioral skills using the techniques of modeling, coaching, and positive reinforcement to remedy specific skill deficits and environmental conditions. Followup reviews for up to 42 months after termination of interventions revealed that improvement in specific skills was maintained.[170]

Behavioral techniques appear to be very effective with neglectful families because they break problems down into manageable components, emphasize immediate positive reinforcement for limited improvements, include real-life application and practice to acquire skills, and provide for followup to maintain gains.[171] Because of the emphasis on skills acquisition and changing behaviors, the results appear to endure, whereas other efforts to provide supportive services indicate that improvements made by neglectful families are lost when intensive, supportive services are withdrawn at termination.[172]

The use of printed material, books, charts, or other handouts as part of the intervention has also proved to be useful with neglectful families. "Props such as these can enhance generalization and maintenance of treatment effects because they assist the use of intervention ideas in the home when the practitioner is not present. They may also enhance needed structure in the home environment and serve as visible reminders of concepts and techniques used in the treatment."[173]

Because neglectful parents typically have poor social/interactional skills, behavioral interventions to teach social skills have proven to be an essential component of successful programs, such as the Homebuilders family preservation program.[174] Neglectful parents often lack basic verbal/social interaction skills necessary for group participation and for initiating and maintaining social relationships. The use of modeling, coaching, rehearsing, and feedback, individually and then in support groups, can significantly enhance neglectful parents' social skills and result in strengthened informal support networks.[175]

Interventions to Strengthen Informal Support Networks

The informal social networks of neglectful parents are typically closed, unstable, and tend to be dominated by often critical, nonsupportive relatives.[176] They do not provide the kinds of tangible aid, advice and guidance, or social and emotional support that parents often call on to help with parenting. The members of their social networks typically share and reinforce the neglectful parenting norms and behavior. Neglectful families often lack the social skills to maintain or to expand their social networks.

Interventions to enhance network supports include:[177]

- Direct intervention by the professional into the family's support network (e.g., neighbors, siblings, and children's fathers) to mediate, facilitate communication, problem solve, modify, and reframe

negative, dysfunctional perceptions of the neglectful parent and/or the parent's negative perceptions of members of their support networks.

- Use of volunteers and parent aides to expand and enrich impoverished resources of networks and provide new information, positive norms, and helpful suggestions about child care.

- Social skills training to teach basic communication and social skills individually and in parent support groups through modeling, practice, rehearsal, and reinforcement. Teaching neglectful parents to make and maintain friendships and to reciprocate aid received from others, facilitates mutually supportive linkages.

- Parent support groups that provide safe opportunities for development of social skills and for making new friends to expand networks of support.

- Identification, linking, and consultation with indigenous "neighborhood natural helpers" (neighbors with recognized natural helping skills) to enhance the parent's informal helping network.

- Linking neglectful parents with existing supportive resources in the community, e.g., church, school, or neighborhood groups.

Use of Paraprofessional Parent-Aides and Volunteers

The use of paraprofessionals to support and supplement the interventions of professionals has proven to enhance the effectiveness of interventions with neglectful parents.[178] Paid or volunteer paraprofessionals provide essential transportation to enable parents and children to obtain supportive community services and provide emotional support, supplemental child care and nurturing, home management training, and help with problem solving.[179] Paraprofessionals have also been trained to teach neglectful parents structured learning interaction exercises for use with their children. For example, parents are taught to use toys to teach children colors, shapes, and names of animals.[180]

The services provided by paraprofessionals cannot replace the trained professional helper. However, the combination is a cost-effective way to enhance the effectiveness of interventions.[181] It is essential that paraprofessionals be well trained, have clearly defined roles and tasks, and have ongoing professional consultation and supervision.

TREATMENT OF NEGLECTED CHILDREN

Most intervention programs with neglectful families focus services on the parents, and few offer direct therapeutic services to the children.[182] Removal of children and placement in foster care to assure the safety of the child is the most widely used direct intervention with children. Demonstration projects, which provided other forms of direct intervention with children to remedy the effects of neglect, showed promising results.

Daro's review of the 19 demonstration projects providing direct services for abused and neglected children revealed improvements in all areas of functioning for over 70 percent of the children served. Group counseling, temporary shelter, and personal skill development classes were effective interventions with adolescents. Therapeutic day care services for preschool children proved to be the most effective service for both the neglected and physically abused children served by the 19 projects reviewed. Removal and placement of children resulted in reduced rates of repeated maltreatment for children and adolescents.[183]

Howing, Wodarski, Kurtz, and Gaudin have proposed a social skills training model for neglected and abused children to remedy developmental skills deficits.[184] The model relies on learning theory and the effectiveness of social skills training with adults as well as with socially withdrawn and aggressive children.

Longitudinal studies indicate that child victims of neglect suffer serious developmental deficits. Remediation of these consequences of neglect requires interventions to supplement the inadequate nurturing that children receive from their parents. The results of the existing treatment research indicate that much more of the resources for intervention should be devoted to direct therapeutic efforts with preschool, school-aged, and teenage children who are victims of neglect.

Therapeutic Child Care for Young Children

Child care programs for children with specially designed therapeutic activities to provide stimulation, cultural enrichment, and development of motor skills and social skills have proven to have a significant impact on the child's functioning and the prevention of repeated maltreatment by parents.[185] Therapeutic child care requires thorough individual assessments to identify specific cognitive, physical, emotional, and behavioral problems and intensive, daily contact between the children and the child care staff to carry out the planned therapeutic activities to meet specific goals for each child. Child care staff must be well trained to understand the negative developmental effects of neglect and provide the therapeutic interactions with the children. Neglectful parents should also be involved in the program and be receiving simultaneous intervention to remedy deficits in parenting.

From their evaluation of four therapeutic child care projects for NCCAN, Berkeley Planning Associates developed a list of essential characteristics for these programs for preschoolers:[186]

Physical Setting and Equipment Needs

- Safe and comfortable environment to enhance the emotional and physical growth of the children.
- Large indoor space for movement, with specific areas and/or separate room(s) for quiet and active play, reduced stimulation, retreat, behavior problems, and counseling/therapy.
- Enclosed outdoor area for children to play in, weather permitting.
- Variety of toys and materials that are stimulating, age-appropriate, and stored in areas that are accessible to the children.
- Kitchen.
- Door-to-door transportation provided for children (and parents, as needed) and for field trips.

Staff Characteristics, Qualities, Skills, and Training

- Low child-to-staff ratio (2–6:1). Lower ratio for very young children and more disruptive children; higher ratio for children 2 years and older.
- Low enrollment in each setting. If one child care provider is in his/her own home, 4–6 children; for a group setting with multiple caregivers, 8–10 children.

- Knowledge of and ability to apply child development theory.
- Good observational skills (ability to observe and assess child's deficits and strengths).
- Flexibility.
- Ability to model good parenting to parents and appropriate behavior to children.
- Acceptance and understanding of parents.
- Awareness of community systems and resources.
- Staff trained in a variety of disciplines (e.g., child development, arts, special education, developmental psychology, etc.).
- Staff mix (e.g., sex, race, and age).
- A staff support group.
- Ongoing, inservice training for staff.
- Paid psychologist/psychiatrist for consultation.

Program Philosophy and Service Elements

- Clear admission criteria and intake procedures.
- Multidisciplinary consultation team for evaluation, treatment planning, and progress assessment input.
- Individualized treatment program, written and updated on each child with ongoing supervision and consultation.
- Structured day program for children, with a routine curriculum and schedule (4–5 days a week, 4–6 hours a day).
- Play therapy.
- Provision of high-quality nutrition for children (and parents) during program attendance.
- Infant intervention for children under 18 months of age, who are too young for structured therapeutic child care, but in need of infant stimulation and supervised parent/child play interaction.
- Parent participation in the program, dealing with their needs as well as their children's by providing supervised parent/child interaction and home visits for modeling parenting and training parenting skills, for observation, and for establishing a therapeutic relationship; specific training on child development and their child's special needs; and services for parents themselves (e.g., individual or group counseling/therapy, recreational activities, etc.).

- Separate staff serving and advocating for children and parents.
- Established and understanding community support network (medical, legal, and protective services).
- Planning and recommendation/referral for after-care services.
- Followup inquiries on families (particularly children's development) after leaving program.

Programs for Older Children and Adolescents

School-aged children who are victims of neglect have serious deficits in cognitive and academic skills that require intervention to prevent school failure and dropout and a continuing downward cycle of functioning.[187] School-based and community programs are required to remedy the child's social and learning deficits. Examples of preventive programs and services for school-aged children and adolescents follow:

- Special education programs with low teacher-to-child ratios, structured learning-by-doing activities, positive reinforcement, and the best computer-assisted learning technology available help remedy deficits in cognitive stimulation and motivation to learn.
- School- or community-based tutorial programs using professional teachers or volunteers provides neglected children and adolescents with necessary academic help and encouragement and a relationship with a nurturing adult to help overcome academic deficits.
- Group counseling and personal skills development classes for older children and adolescents provide opportunities for developing life skills appropriate to age and developmental level. These programs have been found to improve functioning and reduce the likelihood of further maltreatment for maltreated adolescents.[188] Groups are especially appropriate with younger maltreated children because their observations and interpretations of commonly shared experiences exert a corrective influence on one another.[189]
- Volunteer or paid paraprofessional parent aides programs provide one-to-one assistance to parents within child care activities and also provide supplemental parenting to children while parents are learning to improve their child caring abilities.
- Volunteer big brothers and big sisters provide neglected children with emotional nurturing, tutoring, cultural enrichment, recreation activities, and positive role modeling as well as vocational and career counseling.

Out-of-Home Placement of Children

The number of children in foster care increased 27 percent from 1986 to 1989.[190] As the epidemic of drug abuse continues to grow, increasing numbers of children are being removed from their homes for neglect. Although foster care is employed as a temporary measure, for many children, months turn into years, and there are multiple placements in a series of foster homes over the years. A large percentage of the more than 350,000 children in out-of-home care in the United States are placed because of child neglect.

Making the decision to separate a neglected child from his/her parents is one of the most difficult decisions to be made by professional helpers. A CPS caseworker must make the difficult choice between leaving a

child in a home where the level of care is less than adequate, and there is danger of injury to the child or disruption to the crucial psychological bond with a parent figure. Wald has argued persuasively for the priority of preserving the parental relationship unless there is demonstrable or imminent serious physical danger to the child.[191] The enactment of the Federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96–272) signaled the initiation of a national policy that mandates that State CPS agencies make "reasonable efforts" to provide services to families to avoid placement of children or to reunify families in a timely manner once placement has occurred.[192] Nevertheless, in many cases of neglect, children must be removed to protect them from serious, life-threatening harm because of abandonment, malnutrition, homelessness, or other forms of severe neglect.

As described earlier, risk assessment measures are being used in many States to assist CPS caseworkers in assessing the child's safety in his/her own home. Research is not yet available to support the effectiveness of these risk assessment models for making placement decisions. There is some empirical evidence of a tendency to rate neglected children as at lower risk than other maltreated children.[193]

The following criteria should be considered when assessing the need for placement:

- **Severity of the harm or imminent danger to the child's physical health.** Is the child seriously ill or in imminent danger of serious illness or injury? Children who are suffering from malnutrition, serious physical illness, in extremely dangerous, unsafe living situations, or who are abandoned or young children who must depend on mothers addicted to cocaine are at risk of serious, life-threatening injury or illness.

- **Age and disability of the child.** Most child fatalities from child maltreatment occur among children under age 3. Infants and toddlers are the most vulnerable to serious harm. Young children with mental or physical disabilities are also more vulnerable.

On the other hand, younger children are less able to tolerate separation from parents even for short periods of time. A continuous relationship with a nurturing adult when there is good attachment is crucial for children between the ages of 3 months to 3 years. Separation of more than a few days can be very traumatic at this age because children are unable to sustain a clear image of the parent, cannot express their own needs, and lack the words to express the grief that they feel at being separated. Older, school-aged children are able to tolerate longer separations.

- **Parent–child bond.** How strong is the existing psychological attachment between the parent and the child? Does the parent–child interaction indicate strong psychological bonding? Disruption of a strong attachment between parent and the infant or young child may have serious developmental consequences for the child. In the absence of indication of strong bonding, placement is less damaging.

- **History of child maltreatment.** Is the neglect chronic or due to recent stressful life events? Have there been prior placements outside the home? Chronic neglect and prior placements are indicative of greater risk to the child.

- **Parent's motivation/capacity to improve adequacy of child care.** Does the parent acknowledge severely inadequate care? Does the parent's behavior indicate minimal willingness to improve the level of care? Does the parent have the mental and physical ability to provide minimally adequate care? Does the parent have a serious alcohol or drug problem?

- **Availability of supplemental care givers.** Are there other able, responsible adults in the home who, besides the parent, can care for the child? Is there a supportive partner to share the child care responsibilities? Are there neighbors who can provide child care or supervision after school?

- **Availability of supportive community services.** Are the supportive services needed to improve the adequacy of child care and assure the child's safety available to the family? Emergency food, clothing, financial assistance, mental health and substance abuse treatment, and homemaker services are often necessary. Is adequate, affordable child day care available? Is after school supervision available from schools or community recreation programs? These crucial services are often needed to maintain the child safely in the home.

Reunification Planning

If temporary placement of the child outside the home is necessary, a service/treatment plan must be developed with the family specifying what must be accomplished, when, and by whom in order for reunification to occur. The plan should provide:

- a definite projected time for returning the child to the parents;

- specific goals to be achieved prior to the child's return; and

- specific actions to be taken by the parents, foster parents, and professional helpers to facilitate the accomplishment of the goals and the return of the child.

Consistent professional support and followup with the family on scheduled activities and goals are essential. The reunification plan represents a partnership in problem solving.

To facilitate reunification, periodic formal review of case service plans by CPS agency administrative panels, citizen review panels, or the court is practiced in most localities. Service plans are reviewed at 6-month intervals to identify progress toward the child's return home. These procedures offer promise of reducing the stay of children in out-of-home care.

LEGAL INTERVENTION WITH NEGLECTFUL FAMILIES

Involvement of law enforcement and the courts is less frequently used with neglectful families than in the case of physical and sexual abuse. Legal intervention is sometimes necessary, however, to ensure the safety of the neglected child and to bring about change in the family system. Formal confrontation in court of the family's failure to meet minimally adequate child care standards may create the tension necessary for the family to see the unacceptability of its child care and to move toward providing adequate care. More often, the confrontation that comes from the neglect report and the CPS investigation is sufficient to mobilize family energy toward needed change.

CPS caseworkers must balance an official, authoritative stance with a helper role. Although designated by law to investigate reports of neglect, the primary task of the caseworker is to "sell" oneself as a genuine, effective helper. This requires that the caseworker balance the use of confrontation and challenging skills with empathy and supportive help. Neglectful families must clearly understand that their child care is unacceptable; yet, be encouraged by the caseworker's readiness to help them to improve.

Termination of Parental Rights

In extreme cases of child neglect, when persistent intervention efforts have failed to bring about the necessary minimally adequate level of care, and the family's response offers little hope of providing adequate care, court action to terminate parental rights is necessary to free the child for adoption. A decision to pursue termination of parental rights should be made only after consultation with the CPS supervisor and other professionals and after exhausting all alternatives for preserving the family. Termination proceedings in court require that the CPS caseworker be well prepared with factual observations, written documentation, and witnesses if available, to convince the court of the wisdom and justice of this action.[194] The presumption in most juvenile and family courts is in favor of the rights of the biological parent. Convincing evidence must be presented to prove that parental care is less than minimally adequate, likely to remain so, and that adoption is the least detrimental alternative for the child.

For more detailed information regarding the role of the courts in child abuse and neglect cases, see *Working With the Courts in Child Protection*, another manual in this series.

PREVENTING BURNOUT

Polansky, et al. have described the contagious apathy of chronically neglectful families that often "infects" their professional helpers.[195] The combined effects of poverty, personal deficits, lack of informal supports, and environmental stresses weigh heavily upon professionals and volunteers who work with neglectful families.

The daily struggle to provide effective intervention with caseloads of 30 or more neglectful families, when community resources for the necessary supportive services are sparse or nonexistent, takes its toll. The result is often a burnout syndrome that manifests itself through symptoms of physical illness, emotional exhaustion, a sense of failure in personal accomplishment, and depersonalization of clients.[196] Professional helpers, afflicted with these symptoms, are unable to instill the sense of hope that is so essential in mobilizing positive energies for change in neglectful families.

Learning how to cope with stress is essential for preventing burnout. Professionals helpers need to identify and understand the nature of their stress-related anxiety and tension, assess their current coping methods, and develop effective coping strategies. Such strategies include cognitive coping strategies (e.g., reframing problems, making positive self-statements, assessing expectations, and using imagery); enhancing body awareness and making mind-body connections; biofeedback techniques; relaxation exercises; and physical exercise and fitness.[197]

Assessing and modifying unrealistic treatment goals and personal expectations are particularly important for those who work with neglectful families. Setting goals for improved family functioning that are achievable often helps to alleviate professional frustration and stress.

Burnout is also related to the work climate. Organizational structures that encourage professional judgment and autonomy, provide support, and offer consistency between professional and organizational goals help greatly to prevent burnout.[198]

Agency administrators also must be realistic in their expectations of CPS staff; make concerted efforts to reduce unnecessary paperwork, rules, and regulations; and create work units that encourage open communication of feelings and ideas.[199] Staff must be encouraged by administrators to make constructive suggestions for modifying stress-producing organizational rules, procedures, and norms.

Further, burnout can be minimized for caseworkers by:

- providing skilled, supportive supervision and multidisciplinary teams to assist in decision making;
- establishing caseloads of 20 families or less;
- managing caseload assignments to limit the number of chronic neglect cases assigned to any one caseworker;
- making selective use of intensive, family preservation services; and
- providing competitive salaries, merit increases, and fringe and leave benefits.

Last, it is important to emphasize the importance of training opportunities for CPS staff. Conference and workshops are great morale boosters, offering a springboard for renewal of energy and reinspiration. Training also keeps staff up-to-date in research and practice, instilling professional confidence and competence.

SUMMARY

Each neglectful family presents its own intervention challenges to the CPS caseworker. Operating within a framework that instills hope in the family, the caseworker is in the critical position of matching the family with needed services. There are a wide array of intervention strategies to consider, ranging from basic assistance with the necessities of life to intensive family therapy. Intervention targeted to the child holds particular promise in remedying the damaging effect of neglect and in preventing a continuation of the neglect cycle. CPS caseworkers, as well as others who work with neglectful families, must employ personal stress-reducing strategies to maintain the commitment necessary for successful intervention.

PREVENTION OF NEGLECT

The tragic consequences of child neglect suggest that significantly greater efforts should be directed toward prevention. Prevention requires the development of a range of services to parents at risk of neglect and their children, who are potential victims. Prevention of neglect requires action on three levels:

- Primary prevention is directed at the general population with the goal of stopping neglect from occurring.

- Secondary prevention calls for targeting families at high risk of neglect and alleviating conditions associated with the problem.

- Tertiary prevention entails targeting services to neglecting parents and their children to remedy the neglect and its consequences on the children and prevent its recurrence.

Prevention of neglect requires action on all three levels.

PRIMARY PREVENTION

Primary prevention of neglect requires public education efforts through media, especially television, to raise the awareness of the general public and decision makers about the enormous dimensions of child neglect in the United States, its strong association with being poor and disadvantaged, and its damaging effects on children. Communities must understand the need for more adequate public programs and services to support parents in their efforts to care for children. All parents need support and help with the very demanding job of nurturing children. Public education must also seek to raise the consciousness of professionals, of parents, and their potentially supportive neighbors, friends, and relatives about the needs of children to be physically and emotionally nurtured and educated.

Primary prevention requires that public services be available in the community to support the efforts of parents to provide adequate care for their children. When these services are unavailable to parents, children are at risk for neglect. The necessary services include the following:

- Affordable, geographically accessible health care for mothers and children that includes prenatal and obstetric care, preventive pediatric care and treatment for illness, public health screening, health promotion, and immunization and other disease prevention services.

- High-quality public education with curricula that includes age-appropriate life skills training for children and parent education for all older elementary and high school students and adults.

- Parks and recreation programs for children of all ages offered through public and private agencies to provide safe activities to enhance physical, intellectual, social, and emotional development and after school supervision for school-aged children.

SECONDARY PREVENTION

The targeting of high-risk groups to prevent the occurrence of neglect encompasses a range of strategies.

Remedying Poverty

Preventing neglect requires attention to the strong association between child neglect and poverty. The majority of families reported for neglect are also poor. The rate of known neglect is reported to be nine times as great among families with incomes under $15,000 per year as those with incomes over $15,000 per year.[200] Over 20 percent of all children in the United States, 45 percent of Afro-American children, and almost 40 percent of Hispanic children are at high-risk of neglect because they live in poverty.[201] Poverty creates stress that often overwhelms the coping abilities of parents.

Preventing neglect among the poor requires the provision of adequate income supplements and food; affordable housing, health care, and child day care; education; job training; and employment opportunities.

Early Childhood Education

Early childhood education programs for preschool children have documented their effectiveness in significantly enhancing the cognitive and social development of children from impoverished families. Numerous studies have documented the significant and enduring improvements in intelligence, cognitive development, academic achievement, child health, and social emotional development for children who were enrolled in full-year Head Start preschool programs.[202] Given the serious cognitive and academic deficits identified in child victims of neglect, the provision of preschool early intervention programs, such as Head Start, is clearly indicated for neglected children. The High Scope/Perry Preschool Program,[203] the Houston Parent-Child Development Center Project,[204] and the Carolina Early Intervention Program[205] have demonstrated cost-effective results for as long as 25 years after the preschool child's participation in the program. When compared with children from poor families who did not participate in the program, children who participated in the Perry Preschool Program were clearly more successful and manifested less problem behavior in school. At age 19 the children who participated were more likely to be employed, less likely to be on welfare, and were less likely to be involved in delinquency or criminal behavior.

Although high-quality early childhood intervention programs such as these cost about one-and-a-half times the normal per pupil expenditure in the United States, the Perry Program demonstrated cost effectiveness. For every dollar invested in the 30-week Perry Program for children at age 4, taxpayers received almost $6.00 in benefits from savings in K–12 educational expenditures, crimes prevented, and decreased welfare payments, and from increased taxes paid on higher wages earned by the graduates of the program.[206]

Home Health Visitation

Early intervention with parents identified as high risk for neglect, using lay or professional home health visitation, has proven to be an effective prevention strategy. High-risk parents may be identified by reason of their poverty, mental retardation, drug abuse, or lack of social support; by their own history of being maltreated; by observing parent–infant interactions for indicators of poor bonding; or by use of standard risk assessment instruments. Identifying high-risk factors that reliably predict neglect is still an elementary inexact science requiring further research, but clearly the parental groups listed above are at higher risk than the general population.[207]

Provision of prenatal and postnatal inhome visitation by nurses, other professional helpers, or paraprofessional parent aides to young, first-time parents at high risk for neglect is one form of early intervention. Home visitors initiate contact with the mothers during their pregnancy or at the time of their delivery in the hospital, and provide followup inhome visits for up to 2 years.

In one successful program, home health nurses instructed high-risk parents in normal child development and child care practices, mobilized informal support and involvement in parenting tasks, and linked families with community health and social services. Subsequent reports of abuse and neglect were significantly lower for the young, single, and low SES parents, who received the home visitation prenatally and for the next 2 years (4 percent), than for those who received only developmental screening and free transportation for medical appointments (19 percent).[208]

Hawaii's Healthy Start program utilizes trained paraprofessionals to deliver followup, inhome visitation to high-risk mothers. Based on the success of the program in Hawaii, the program is being adopted as a child abuse prevention model in many States. The program has been successful in preventing neglect in 99 percent of the high-risk families served over a 4-year period.[209]

In other programs, lay home visitors are used to make contact with the new mother in the hospital at the time of delivery and visit in the home twice during the first month and at least monthly thereafter for up to 1 year. Lay home visitors are trained to teach parent–infant interaction, home management, specific child care, and problem-solving skills. The goal is to reduce family stress by assisting in problem solving and connecting families with medical and social services to meet needs identified by the family. Lay home visitors also provide emotional support, encouragement, and guidance to young parents during the stressful adjustment to the demands of parenting.[210]

Parents at high risk of neglecting or abusing their children, by reason of their own history of abuse or neglect, are the focus of the STEEP program (Steps Toward Effective, Enjoyable Parenting).[211] Mothers are recruited through obstetric clinics during their pregnancy. The program begins with home visits during the second trimester of pregnancy to help mothers deal with feelings about pregnancy and impending parenting responsibilities. Home visits by a "family life facilitator" continue every other week until the baby is 1 year old. From the time the babies are about 4 weeks old, the facilitator conducts biweekly group sessions with groups of eight mothers and their infants. The facilitators provide basic child development information, coach mothers to respond appropriately to their infant's cues and signals, and help mothers recognize their infants' special characteristics and needs. The teaching method is demonstration, with active involvement of mother and baby, not didactic teaching.

A major goal of the STEEP program is to help mothers to modify negative, dysfunctional "representational images" of themselves that flow from their own history of being abused or neglected. Mothers who are products of child maltreatment often view themselves as incapable of being good parents to their children. The facilitator encourages active parent discussion and reassessment of early life experiences and their influence on current parenting. A strong theme of the program is empowerment of the parent.

Family Planning

Chronically neglectful families tend to be large families with more than the average number of children. Caring for three or more children with insufficient resources creates unusual stress, setting the stage for neglect. Growing families need help choosing family planning methods suited to their moral and cultural values and to their abilities to successfully use various birth control methods.

Parent Skills Training

Parent education programs that are structured and designed to focus on specific parenting skills have been successful in improving the adequacy of child care provided by high-risk parents.[212] In selecting a parent education program, the professional must always consider the program's cultural/ethnic appropriateness for the target family or group. Parent education programs and materials must be developed and written in language that is understandable by parents with limited education and literacy levels. Parent education programs offered through neighborhood schools, public health agencies, mental health centers, churches, and other organizations may be especially attuned to cultural factors affecting parents in the immediate community.

The WINNING program developed by Dangel and Polster uses a series of eight instructional video tapes that introduce the parent to basic child management skills.[213] Bavolek and Comstock's Nurturing Program includes audiovisual aids and a structured format that can be used with groups or individually in the parent's home.[214]

The MELD (Minnesota Early Learning Demonstration) is an intensive 2-year center-based parent education and support program for young mothers. It offers special programs for Hispanic families, hearing impaired parents, and parents of children with special needs. Groups of 10–20 mothers meet for 2 to 3 hours weekly over 2 years, in four 6-month phases. They learn about health care, child development, home and child management, and personal growth. Immediate outcomes demonstrated by the program are encouraging.[215]

The "Small Wonder" kit uses structured mother–infant interaction exercises to guide and teach mothers to cognitively stimulate their infants and young children through eye contact and verbalizing with the infant and toddler about shape and color of simple objects.[216] Thus, mothers whose interactions with their infants and young children indicate poor stimulation and nurturing abilities can be taught ways to improve stimulation and increase positive verbal and nonverbal communication.

Further instruction using verbal and pictorial prompts, modeling, feedback, and social reinforcement has been successfully used with mentally handicapped parents to improve infant stimulation, nurturing interactions, and other child care skills to prevent neglect.[217]

Parent skills training can be offered in groups or individually, by professional helpers, or by trained volunteers. The effectiveness of group instruction is usually greatly enhanced when combined with inhome, one-to-one demonstration, coaching, and direct positive reinforcement of parental efforts to improve.

Strengthening Social Network Supports

Parents benefit from strong supportive networks of neighbors, friends, and relatives and from involvement with churches and other supportive organizations. Efforts to strengthen social network supports have proven to be an effective intervention with high-risk and neglectful families.[218] Assessment of stress level and supports using standard instruments or informal questioning can help to identify parents in need of such intervention.[219] Improving supports and reducing negative external influences can enable parents, under high stress from poverty and other life events, to cope more effectively with the demands of parenting.

TERTIARY PREVENTION

As previously discussed in the chapters on assessment and intervention, preventing the recurrence of child neglect in families is a primary CPS goal. Based on the causal factors and on conditions contributing to the family's neglect, the CPS caseworker develops and implements a service plan. In essence, any service or

intervention selected for inclusion in the plan represents a tertiary prevention strategy. (For a delineation of services and interventions, which also serve as tertiary prevention strategies, see "Intervention.")

Recent research, such as Daro's review of demonstration programs aimed at helping neglectful families, underscores the importance of direct intervention with neglected children as a tertiary prevention strategy. Intervention targeted to children shows success in alleviating the damaging consequences of child neglect.[220] By being helped to achieve improved functioning during childhood, the neglected child is more likely to succeed as a parent in adulthood.

Another possible tertiary prevention outcome of direct intervention with neglected children revolves around the parents. The efforts of parents to improve their parenting abilities may be bolstered by evidence of improvement in their children. Progress in the child's development, better performance in school, and/or more manageable child behaviors at home help neglectful parents to feel encouraged and hopeful about the future.

FUNDING FOR PREVENTIVE SERVICES

Providing the range of preventive services to all parents and children would be enormously expensive. Parents who are reasonably well prepared for parenting responsibilities, by reason of positive nurturing, education, and psychological maturity, do not require home health visitation services, although it may be desirable to offer these service to all young parents. Rather it is more financially feasible to focus preventive services on families most in need; i.e., families at high-risk for child neglect.

Although further research is necessary to refine identification of high-risk families, preventive services for families considered to be at risk can be initiated or expanded now at relatively low cost. Paraprofessionals and volunteers can be trained to provide parent education. Volunteer parent aides can be recruited to make home visits and help families in numerous ways. Public schools and health care facilities, churches, neighborhood groups, and other community-based organizations can be tapped as resources for high-risk families.

Even by narrowing the focus of prevention to high-risk families, not all needed services can be funded. There are many competing priorities for limited funds. However, initial steps aimed at prevention can be taken, such as developing just one new program on preventive service. In the past, even well-funded demonstration projects serving neglectful families have not paid sufficient attention to the children's needs for direct intervention.[221] Focusing a program or services on child victims of neglect would be a good first step toward prevention.

Opportunities for funding preventive services may not be abundant, but they do exist. Recently, States have passed legislation and appropriated funds to support prevention efforts in child maltreatment. Forty-nine States have initiated surcharges on marriage licenses, birth certificates, and/or divorce decrees to create Children's Trust and/or Prevention Funds to provide funding for prevention of child abuse and neglect. Funding for prevention is also provided in many States through legislative appropriations and donations earmarked on State income tax forms. A wide variety of primary and secondary prevention programs have been initiated with children's trust fund resources. The Child Abuse Prevention and Treatment Act (P.L. 102–295) provides matching funds to States with such Children's Trust funds to support community-based child abuse and neglect prevention programs.

Private industry has also contributed to prevention efforts by expanding fringe benefit packages to employees that include employer subsidized on-site child care; flexible work time options for parents; and employee assistance programs to assist personnel with marital problems, child care and management, consumer and

budgeting problems, substance abuse, and stress reduction.[222] These employer-provided benefits can help to reduce role conflicts and stress on parents and provide convenient, affordable child care and problem-focused counseling for parents. They also offer opportunities for early identification of child neglect and for referral for appropriate remedial or supportive services in the community.

SOCIAL POLICY IMPLICATIONS

The causes of child neglect have been identified at individual, family, and community system levels. Public social policies must address the causal factors at all three levels to provide the necessary supportive and preventive services to enable neglectful and high-risk parents to successfully carry out the parenting role.

ATTENTION TO POVERTY

The strong association of neglect with poverty demands the allocation of greater public and private resources to the remediation of the poverty that afflicts 20 percent of the children in the United States. One long-term solution lies in improving public education, particularly for families of color, to more adequately prepare the next generation for employment in fields offering adequate wages and job opportunities. For the immediate, critical short-term, public social policy must ensure that a range of remedial and supportive services are available to emotionally and economically impoverished families to prevent or remedy neglect. The services required are the following:

- **Financial assistance for mothers and children**. The current AFDC program provides financial assistance primarily to single parents at a less than poverty level of subsistence. Children in these families are at high risk of neglect. Prevention of neglect requires adequate financial assistance to mothers of young children and subsidized housing and food supplements.

- **Job training, employment, and child care services**. These programs are necessary to enable parents to become self supporting as their children become older and enter school. Income supplements, health benefits, subsidized housing, and food supplements for the working poor are also needed to fill the gap between minimum wage income and meeting the basic needs of children in these families.

IMPROVEMENTS IN PUBLIC SOCIAL UTILITIES

The necessary health, education, and social services to provide societal supports for the difficult and demanding job of parenting must be available to assist parents who lack sufficient personal, financial, and social resources to provide minimally adequate care for their children. Kahn has called these basic services "social utilities."[223]

Health Care

There is an urgent need in the United States to extend basic health care services to an estimated 10 percent of the children and their parents in lower SES and working class families who are without health insurance.[224] The 1988 National Incidence Study estimates include over 100,000 children who were victims of medical neglect. Prenatal and obstetric care for mothers; periodic health screening; and preventive well child care and treatment for illness, immunizations, and health promotion through schools, child care centers, and public health departments must be made available and accessible to all mothers and children. Public funding will be required to support these services for impoverished families.

Education

High-quality public education is essential for the short-range as well as the long-range solutions to poverty. Schools must become the primary vehicle for preparing youth for productive employment and for providing parenting training for children and adults. Schools in low-income areas will require a greater share of resources to provide the same quality of education enjoyed in more affluent areas. Schools in these areas with high-risk populations must provide more remedial and supportive services to supplement the parents' lack of personal, social, and financial resources. Schools in high-risk, low-income areas must provide lower pupil–teacher ratios, tutorial services, individual and group counseling, after school supervision, and parent education/support groups. Teachers will need training and consultation to effectively manage neglected children whose academic, social, and developmental delays require special educational approaches.

Schools are in a key position to offer preparation for parenting and life skills development beginning with very young children in kindergarten through critical preteen and teenage years, and for young adult parents through extended hours programs. Curricula should include child development and child care skills, interpersonal skills, problem-solving and decision-making skills, budgeting, health maintenance/physical fitness, and identity enhancement skills.[225] Development of these critical life skills would do much to prevent neglect in the current and next generation of parents.

Child Care Services

Some neglect could be prevented if affordable, high-quality group and family child care services were accessible to all families. High-quality child care is expensive and beyond the financial resources of lower income families. Recent Federal legislation has significantly increased the availability of publicly subsidized child care, but there remains a large gap in the availability of affordable child care for poor children. Schools, day care centers, and community youth and recreation agencies must expand the availability of supervised after school care for school-aged children.

Mental Health Services

Depression has been identified as a frequent contributing cause of child neglect.[226] It is also the most frequently diagnosed mental health problem in the United States. Neglected children also manifest cognitive and behavioral problems that require mental health intervention.[227]

A 1982 study, supported to the Children's Defense Fund, called attention to the serious undersupply of mental health services for children and adolescents.[228] The study estimated that two-thirds of the children and adolescents in the United States, who needed mental health services, got either no services or inappropriate ones. Abused and neglected children were identified along with adolescents and children of substance abuse users as among the most likely to be unserved or underserved.

A range of high-quality, affordable, geographically accessible preventive and remedial mental health services must be made available to neglectful parents with mental health problems and for child and adolescent victims of neglect. Services should include:

- community education concerning the needs of children and age appropriate expectations for children;
- parent education groups that teach specific child care and management skills;

- consultation to school personnel, public health, and personnel in other community social service agencies to assist in identification of child maltreatment and provision of age-appropriate activities for neglected children to supplement parents' efforts;

- appropriate therapeutic treatment for diagnosed depression and other mental health problems of parents and children, which may require home visits and services beyond short-term, crisis intervention; and

- group and individual counseling for children and adolescents made available through schools that focus on development of interpersonal social skills, problem solving, and self-development skills.

Drug Prevention and Treatment

The proportion of cases of neglect involving abuse of alcohol and other drugs has rapidly increased over the past 5 years. Federal drug abuse prevention efforts have emphasized community education and law enforcement, but drug treatment and rehabilitation services are not available for the large numbers of addicts who seek treatment. Preventive education and law enforcement are essential components, and services must be made readily available for drug treatment and rehabilitation to already addicted adults and adolescents. Priority for treatment must be given to pregnant women and parents of young children.

CPS

Increases in Federal, State, and local funding for CPS programs have lagged far behind the 100-percent increases in child abuse and neglect reports during the decade of the 1980's.[229] The enormous increase in cases has overwhelmed the limited staff and resources of the CPS agencies. It has also "had significant effects on the law enforcement agencies, juvenile and criminal courts, prosecutor offices, public defender offices, and mental health agencies involved with investigating, adjudicating, or treating maltreated children and their families."[230] The CPS agencies involved in the investigation of reports, the care and protection of the child victims of maltreatment, and the provision of appropriate services to protect children, prevent placement, and remedy neglect and abuse are the most severely overtaxed.

The current crisis in child welfare demands that private citizens, private sector representatives, public officials, and legislative bodies at local, State, and Federal levels combine their energies to formulate new policies and develop significant additional resources needed.

FUNDING FOR NECESSARY PROGRAMS AND SERVICES

The resources required for providing the necessary treatment and preventive services to protect the children who are victims of neglect are very great. The needed improvements in public health and education programs require significant increases in Federal, State, and local budget allocations. All levels of government are currently struggling to maintain existing services within current revenues. They are also confronted with increasing demands from citizens for radical improvements in health care and public education. The recommended improvements in remedial and preventive services targeted on neglect require even greater allocation of public and private resources.

The remedying of child neglect will be costly, but the costs of not providing the needed preventive and remedial services are also great. The cost of neglected children who will suffer severe learning deficits, school failure, and lost earning potential alone is enormous. Add to that the costs of foster care, crime and

delinquency, economic dependency, and the next generation of parents unable to provide adequate care for their children is even more costly to society.

The costs of providing the needed remedial and preventive services can be minimized and cost effectiveness maximized by using the results from the evaluation of intervention programs. Some guidelines indicated by results of that research include:

- Remedial services for parents combined with services for neglected children are more effective than interventions directed solely on parents. Greater resources should be concentrated on preventive and remedial services that target neglected children. Therapeutic child care, early childhood education programs, and group counseling for school-aged children are some examples of cost-effective services.

- Group methods, family therapy, and use of trained paraprofessionals are more cost effective and should be used over expensive and less effective one-to-one professional counseling.

- Intensive family preservation programs, combined with less intensive followup services, are cost-effective means of preventing undesirable and expensive foster care or institutional placements. They offer the kind of supportive and family focused interventions that are required by neglectful families.

- Home health visitation programs that target identified high-risk mothers are a cost-effective means of preventing neglect.[231]

SERVICE DELIVERY SYSTEMS

Most of the services needed by neglectful or high-risk families can be delivered through existing service structures, that is, schools, public health agencies, hospitals, mental health centers, churches, and other private and nonprofit community agencies. The typical ways in which services are delivered may need modification, however.

Outreach and inhome services are essential with neglectful families. Traditional inoffice psychotherapy and nine-to-five availability for services are not sufficient. Inhome services must be available in evenings and weekends. Because a majority of neglectful families lack telephones and cars, traditional procedures for scheduling appointments are not always possible. Flexibility in scheduling is a must. Drop-in services for primary health care and crisis intervention are yet other needed changes in existing service systems.

SUMMARY

Public social policies must address the causal factors of child neglect at the individual, family, and societal levels. Remediations of poverty and economic dependency and the provision of basic health care, education, child care, and mental health services are essential for the prevention and remediation of child neglect. The child protection system is severely overtaxed and in need of additional resources and new policies. Remedial services must target neglected children as well as parents. Home health visitation programs for high-risk mothers and their children are a key to the prevention of neglect.

GLOSSARY OF TERMS

Acute Malnourishment - the condition by which the child's development is significantly impeded due to inadequate nutritional intake.

Attachment Theory - a developmental theory that emphasizes the relationship between an infant and its caretaker(s). Attachment theory states that the preliminary framework for relationship patterns is established through early childhood relationships, but this framework is subject to change throughout an individual's lifetime.

Behavioral Theory - the theory that attempts to explain the cause–effect relationship between the class of stimulus variables and response variables, with reinforcement stimuli increasing behaviors and punishment stimuli decreasing behaviors.

Burnout - syndrome that manifests itself in symptoms of physical illness or fatigue, emotional exhaustion, a sense of failure in personal accomplishment, and depersonalization of social and professional interactions.

Case Plan - the casework document that outlines the outcomes and goals necessary to be achieved to reduce the risk of maltreatment.

Case Planning - the stage of the CPS case process whereby the CPS caseworker develops a case plan with the family members.

Child Neglect - the failure of a parent or caretaker responsible for the child's care to provide minimally adequate food, clothing, shelter, supervision, and/or medical care for the child.

Child Protective Services (CPS) - the designated social service agency (in most States) to receive reports,investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within larger public social service agencies, such as Departments of Social or Human Services.

Cognitive Theory - as an adjunct to behavioral theory, cognitive or cognitive–behavioral approaches aim to change behavior by changing an individual's cognition (i.e., awareness, perceptions).

Evaluation of Family Progress - the stage of the child protection case process, following the implementation of the case plan, when the CPS caseworker and other treatment providers evaluate and measure changes in the family behaviors and conditions which led to the child abuse or neglect, monitor risk elimination and reduction, and determine when services are no longer necessary.

Family Assessment - the stage of the child protection process when the CPS caseworker, community treatment providers, and the family reach a mutual understanding regarding the most critical needs to be addressed and the strengths on which to build.

Family Systems Theory - a view of how family members interact with one another in relationship patterns that promote and/or accommodate the functioning of the family as a unit (or system).

Family-Focused Intervention - intervention that includes all family members, rather than focusing on one individual primarycare provider. This approach targets the whole family as a dysfunctional unit, not just one individual within that unit.

Initial Assessment - the stage of the child protection case process when the CPS caseworker and other social services personnel determine the validity of the child maltreatment report, assess the risk of maltreatment, and determine the safety of the child and the need for further intervention. Frequently, medical, mental health, law enforcement, and other community providers are involved in assisting in the initial assessment.

Multiservice Intervention - the delivery of a broad range of community services available from multiple providers combinedwith individual counseling, individual and group parenting education, and family therapy.

Nonorganic Failure To Thrive - the condition observed in children whose physical development is recorded at below the third percentile in height or weight for that specific age and for which there is no known medical reason.

Paraprofessional - a trained aide who assists a professional person, such as a teacher or physician.

Primary Prevention - activities targeting a sample of the general population in which to prevent child abuse and neglect from occurring.

Psychotherapy - a method of treatment designed to produce a response by mental rather than physical stimulus, it includes the use of suggestion, persuasion, reeducation, reassurance, and support as well as hypnosis and psychoanalysis.

Risk Assessment - the use of checklists, matrices, standardized scales, and other measurement techniques to determine the likelihood that the child will be maltreated in the future.

Secondary Prevention - activities that are designed to prevent breakdown and dysfunction among families that have been identified as at risk for child abuse and neglect.

Service/Treatment Plan - the casework document developed between the CPS caseworker and the client that outlines the tasks necessary to be accomplished by all parties to achieve goals and outcomes necessary for risk reduction.

Substantiated/Founded - a CPS determination that credible evidence exists that child abuse or neglect has occurred.

Termination of Parental Rights - a legal proceeding to free a child from a parent's legal custody so that the child can be adopted by others. The legal basis for termination of rights differs from State to State, but most consider the failure of the parent to support or communicate with the child for a specified period of time, parental failure to improve home conditions, extreme or repeated neglect or abuse, parental incapacity to care for the child, or extreme deterioration of the parent–child relationship as grounds for termination of parental rights.

Tertiary Prevention - treatment efforts designed to address situations in which child maltreatment has already occurred with the goals of preventing child maltreatment from occurring in the future and avoiding the harmful effects of child maltreatment.

Unsubstantiated/Unfounded - a CPS determination that credible evidence does *not* exist that child abuse or neglect has occurred.

NOTES

1. U.S. Department of Health and Human Services (DHHS), *Study of National Incidence and Prevalence of Child Abuse and Neglect* (Washington, DC: DHHS, 1988).

2. M. Wald, "State Intervention on Behalf of Neglected Children: Standards for Removal of Children from their Homes, Monitoring the Status of Children in Foster Care and Termination of Parental Rights," *Stanford Law Review* 28(1976):637.

3. M. Wald, "State Intervention on Behalf of Endangered Children: A Proposed Legal Response," *Child Abuse and Neglect* 6(1982):11.

4. I. Wolock and B. Horowitz, "Child Maltreatment and Material Deprivation Among AFDC-Recipient Families," *Social Service Review* 53(1979):179–194.

5. S. J. Zuravin, "Suggestions for Operationally Defining Child Physical Abuse and Physical Neglect," in R. H. Starr and D. A. Wolfe, eds., *The Effects of Child Abuse & Neglect* (New York: Guilford Press, 1991).

6. N. A. Polansky et al., *Damaged Parents* (Chicago: University of Chicago Press, 1987), 15.

7. J. Korbin, "Child Abuse and Neglect: The Cultural Context," in R. E. Helfer and R. S. Kempe, eds., *The Battered Child*, 4th ed., (Chicago: University of Chicago Press, 1987), 23–41.

8. J. M. Giovannoni and R. M. Becera, *Defining Child Abuse* (New York: The Free Press, 1979).

9. N. A. Polansky, P. Ammons, and B. L. Weathersby, "Is There an American Standard of Child Care?" *Social Work* (1983):341–46.

10. J. M. Giovannoni and A. Billingsley, "Child Neglect Among the Poor: A Study of Parental Adequacy in Families of Three Ethnic Groups," *Child Welfare* 49(1970):196-204; L. H. Pelton, *The Social Context of Child Abuse and Neglect* (New York: Human Science Press, 1981); Polansky et al., *Damaged Parents*; American Association for Protecting Young Children, *Highlights of Official Child Neglect and Child Abuse Reporting 1981* (Denver: American Humane Association, 1988); and N. A. Polansky, P. W. Ammons, and J. M. Gaudin, "Loneliness and Isolation in Child Neglect," *Social Casework* 66(1985):38–47.

11. Wolock and Horowitz, "Child Maltreatment and Material Deprivation Among AFDC-Recipient Families," 175–194.

12. U.S. Department of Health and Human Services, *Study of National Incidence and Prevalence of Child Abuse and Neglect*.

13. Ibid.

14. M. A. Jones, Parental Lack of Supervision.

15. Ibid.

16. J. Bopp and T. J. Balch, "The Child Abuse Amendments of 1984 and their Implementing Regulations: A Summary of Issues" *Law and Medicine* 1(1985):129.

17. D. S. Gomby and P. H. Shiono, "Estimating the Number of Substance-Exposed Infants," *The Future of Children* 1(1991):21.

18. D. Kronstadt, "Complex Developmental Issues of Prenatal Drug Exposure," *The Future of Children* 1(1991):39–41.

19. R. S. Kempe and R. B. Goldbloom, "Malnutrition and Growth Retardation (Failure to Thrive) in the Context of Child Abuse and Neglect," in R. E. Helfer and C. H. Kempe, eds., *The Battered Child*, 4th ed., (Chicago: University of Chicago Press, 1987), 312.

20. C. C. Ayoub and J. S. Milner, "Failure to Thrive: Parental Indicators, Types, and Outcomes," *Child Abuse & Neglect* 9(1985):491–499.

21. P. M. Crittenden, "Non-Organic Failure to Thrive: Deprivation or Distortion?" *Infant Mental Health Journal* 8(1987):51–64; and Kempe and Goldbloom, "Malnutrition and Growth Retardation (Failure to Thrive) in the Context of Child Abuse and Neglect," 312.

22. K. Nelson, E. Saunders, and M. J. Landsman, *Chronic Neglect in Perspective: A Study of Chronically Neglecting Families in a Large Metropolitan County*. Final Report. (Oakdale, IA: National Resource Center for Family Based Services, 1990).

23. U. Bronfenbrenner, *The Experimental Ecology of Human Development* (Cambridge, MA: Harvard University Fress, 1979); J. Garbarino, "The Human Ecology of Child Maltreatment: A Conceptual Model for Research," *Journal of Marriage and the Family* 39(1977):7221–7235; and J. Belsky, "Child Maltreatment: An Ecological Integration," *American Psychologist* 4(1980):320–335.

24. J. Belsky and J. Vondra, "Lessons from Child Abuse: The Determinants of Parenting," in D. Cicchetti and V. Carlson, *Child Maltreatment* (Cambridge: Cambridge University Press, 1989), 153–202.

25. Ibid., 168.

26. R. Pianta, B. Egeland, and M. F. Erickson, "The Antecedents of Maltreatment: Results of the Mother-Child Interaction Project," in D. Cicchetti and V. Carlson, *Child Maltreatment* (Cambridge: Cambridge University Press, 1989), 241.

27. P. M. Crittenden and M. D. S. Ainsworth, "Child Maltreatment and Attachment Theory," in D. Cicchetti and V. Carlson, *Child Maltreatment* (Cambridge: Cambridge University Press, 1989), 432–464.

28. Polansky et al., *Damaged Parents*; P. M. Crittenden, "Sibling Interaction: Evidence of a Generational Effect in Maltreating Families," *Child Abuse and Neglect* 8(1984):433–438; Pianta, Egeland, and Erickson, "The Antecedents of Maltreatment: Results of the Mother-Child Interaction Research Project," 203–253; and B. Egeland and M. Erickson, "Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect," *Zero to Three* 11(1990):29–35.

29. B. Egeland, "The Consequences of Physical and Emotional Neglect on the Development of Young Children," *Research Symposium on Child Neglect* (Washington, DC: National Center on Child Abuse and Neglect, 1988).

30. M. Main and R. Goldwyn, "Predicting Rejection of her Infant from Mother's Representation of Her Own Experience: Implications for the Abused-Abusing Intergenerational Cycle," *Child Abuse and Neglect* 8(1984):3203–3217.

31. Polansky et al., *Damaged Parents*, 151.

32. Egeland and Erickson, "Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect," 29–35; and J. Kaufman and E. Zigler, "Do Abused Children Become Abusive Parents?," *American Journal of Orthopsychiatry* 56(1987):186–192.

33. N. Polansky, R. Borgman, and C. DeSaix, *Roots of Futility* (San Francisco: Jossey Bass, 1972).

34. *Ibid.*

35. Polansky et al., *Damaged Parents*, 109.

36. Ibid., 51.

37. W. N. Friedrich, J. D. Tyler, and J. A. Clark, "Personality and Psychophysiological Variables in Abusive, Neglectful and Low-Income Control Mothers," *Journal of Nervous and Mental Disease* 173(1985):449–460.

38. *Ibid.*, 457.

39. Ibid., 459.

40. J. S. Milner and K. R. Robertson, "Comparison of Physical Child Abusers, Intrafamilial Sexual Child Abusers, and Child Neglecters," *Journal of Interpersonal Violence* 5(1990):37–48.

41. M. M. Weissman, E. S. Paykel, and G. L. Klerman, "The Depressed Woman as Mother," *Social Psychiatry* 7(1972):98–108; and C. Longfellow, P. Zelkowitz, and E. Saunders, "The Quality of Mother-Child Relationships," in D. Belle, ed., *Lives in Stress: Women and Depression* (Beverly Hills, CA: Sage, 1981), 163–176.

42. Polansky, Borgman, and DeSaix, *Roots of Futility*.

43. A. H. Green et al., "Psychological Assessment of Child-Abusing, Neglecting, and Normal Mothers," *The Journal of Nervous and Mental Diseases* 168(1980):356–360.

44. S. J. Zuravin, "Child Abuse, Child Neglect and Maternal Depression: Is there a connection?," in *Research Symposium on Child Neglect* (Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1988), 34.

45. J. M. Gaudin et al., "Relationships Among Loneliness, Depression and Social Supports In Neglectful Families," *American Journal of Orthopsychiatry* (In Press).

46. Polansky et al., *Damaged Parents*, 39.

47. Polansky, Borgman, and DeSaix, *Roots of Futility*.

48. Polansky et al., *Damaged Parents*, 115.

49. B. Egeland, "Breaking the Cycle of Abuse: Implications for Prediction and Intervention," in K. Browne, C. Davies, and P. Stratton, eds., *Early Prediction and Prevention of Child Abuse* (Chichester, England: John Wiley, 1988), 92.

50. J. Belsky, "Child Maltreatment: An Ecological Integration," *American Psychologist* 4(1980):320–335.

51. S. T. Azar et al., "Unrealistic Expectations and Problem-Solving Ability in Maltreating and Comparison Mothers," *Journal of Consulting and Clinical Psychology* 52(1984):687–690.

52. Polansky et al., *Damaged Parents*.

53. J. M. Jones and R. L. McNeely, "Mothers Who Neglect and Those Who Do Not: A Comparative Study," *Journal of Contemporary Social Work* (1980):559–567; and R. C. Herrenkohl, E. C. Herrenkohl, and B. P. Egolf, "Circumstances Surrounding the Occurrence of Child Maltreatment," *Journal of Consulting and Clinical Psychology* 51(1983):424–431.

54. Azar et al., "Unrealistic Expectations and Problem-Solving Ability in Maltreating and Comparison Mothers," 687–690; and D. T. Larrance and C. T. Twentyman, "Maternal Attributions and Child Abuse," *Journal of Abnormal Psychology* 92(1983):449–457.

55. M. J. Martin and J. Walters, "Familial Correlates of Selected Types of Child Abuse and Neglect," *Journal of Marriage and the Family* (1982):267–276.

56. National Committee for the Prevention of Child Abuse (NCPCA), "Substance Abuse and Child Abuse," *NCPCA Fact Sheet* (Chicago: NCPCA, 1989), 14.

57. R. Famularo, "Alcoholism and Severe Child Maltreatment," *American Journal of Orthopsychiatry* 53(1986):481–485.

58. *Alcoholism and Child Neglect* (Springfield, IL: Illinois Department of Children and Family Services, 1987), 4.

59. D. Priddy, "A Social Worker's Agony: Working With Children Affected by Crack/Cocaine," *Journal of the National Association of Social Workers* 35(1990):193–288; and C. Johnston, "The Children of Cocaine Addicts: A Study of Twenty-five Inner City Families," *The Social Worker* 58(1990):53–56.

60. Crittenden and Ainsworth, "Child Maltreatment and Attachment Theory"; P. M. Crittenden, "Abusing, Neglectful, Problematic, and Adequate Dyads: Differentiating by Patterns of Interaction," *Merrill-Palmer Quarterly* 27:1–18; and P. M. Crittenden, "Family and Dyadic Patterns of Functioning in Maltreating Families," in K. Browne, C. Davies, and P. Stratton, eds., *Early Prediction and Prevention of Child Abuse* (Chichester, England: John Wiley, 1988), 161–189.

61. Belsky and Vondra, "Lessons from Child Abuse: The Determinants of Parenting," 153–202.

62. U.S. Department of Health and Human Services, *Study of National Incidence and Prevalence of Child Abuse and Neglect.*

63. N. A. Polansky et al., "The Absent Father in Child Neglect," *Social Service Review* (1979):63–74.

64. R. J. Gagan, J. M. Cupoli, and A. H. Watkins, "The Families of Children Who Fail to Thrive: Preliminary Investigations of Parental Deprivation Among Organic and Non-Organic Cases," *Child Abuse and Neglect* 8(1984):93–103; and Kempe and Goldbloom, "Malnutrition and Growth Retardation (Failure to Thrive) in the Context of Child Abuse and Neglect."

65. Polansky et al., *Damaged Parents*; and N. A. Polansky et al., "The Psychological Ecology of the Neglectful Mother," *Child Abuse and Neglect* (1985):265–275.

66. J. M. Giovannoni and A. Billingsley, "Child Neglect Among the Poor: Study of Parental Adequacy in Families of Three Ethnic Groups," *Child Welfare* 19(1970):196–204; and Wolock and Horowitz, "Child Maltreatment and Material Deprivation Among AFDC-Recipient Families," 175–194.

67. U.S. Department of Health and Human Services, *Study of National Incidence and Prevalence of Child Abuse and Neglect.*

68. R. L. Burgess and R. D. Conger, "Family Interaction in Abusive, Neglectful, and Normal Families," *Child Development* 49(1978):1163–1173.

69. Crittenden, "Abusing, Neglecting Problematic, and Adequate Dyads: Differentiating by Patterns of Interaction," 210.

70. P. Crittenden and J. D. Bonvillian, "The Relationship Between Maternal Risk Status and Maternal Sensitivity," *American Journal of Orthopsychiatry* 54(1984):250–62; J. A. Aragona and S. M. Eyeberg, "Neglected Children: Mothers' Report of Child Behavior Problems and Observed Verbal Behavior," *Child Development* 52(1981):596–602; D. M. Bousha and C. T. Twentyman, "Mother-Child Interaction Style in Abuse, Neglect, and Control Groups," *Journal of Abnormal Psychology* 93(1984):106–114; and Azar et al., "Unrealistic Expectations and Problem-Solving Ability in Maltreating and Comparison Mothers," 687–690.

71. Crittenden, "Family and Dyadic Patterns of Functioning in Maltreating Families," 161–189.

72. Ibid., 173.

73. Ibid., 175.

74. American Humane Association, *Highlights of Official Child Neglect and Child Abuse Reporting: 1986* (Denver: American Humane Association, 1988), 26–33; and Nelson, Saunders, and Landsman, *Chronic Neglect in Perspective: A Study of Chronically Neglecting Families in a Large Metropolitan County*, Final Report.

75. Polansky et al., "The Psychological Ecology of the Neglectful Mother," 265–275; Wolock and Horowitz, "Child Maltreatment and Maternal Deprivation Among AFDC-Recipient Families," 175–194; J. Garbarino and D. Chairman, "Identifying High Risk Neighborhoods," in J. Garbarino

and S. H. Stocking, eds., *Protecting Children from Abuse and Neglect* (San Francisco: Jossey-Bass, 1980), 94–108; and American Humane Association, *Highlights of Official Child Neglect and Child Abuse Reporting: 1986*.

76. Polansky et al., *Damaged Parents*; Polansky et al., "The Psychological Ecology of the Neglectful Mother," 265–275; and Wolock and Horowitz, "Child Maltreatment and Maternal Deprivation Among AFDC-Recipient Families," 175–194.

77. J. M. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," *Journal of Applied Social Sciences* 15(1990–1991):97–123; Giovannoni and Billingsley, "Child Neglect Among the Poor: A Study of Parental Adequacy in Families of Three Ethnic Groups," 196–204; and Polansky et al., "The Psychological Ecology of the Neglectful Mother," 265–275.

78. L. H. Pelton, *The Social Context of Child Abuse and Neglect* (New York: Human Science Press, 1981); Polansky et al., "The Psychological Ecology of the Neglectful Mother," 265–275; and Wolock and Horowitz, "Child Maltreatment and Maternal Deprivation Among AFDC-Recipient Families," 175–194.

79. Nelson et al., *Chronic Neglect in Perspective: A Study of Chronically Neglecting Families in a Large Metropolitan County*.

80. American Humane Association, *Highlights of Official Child Neglect and Child Abuse Reporting: 1986*, 33.

81. A. Kadushin, "Neglect in Families," in E. Nunnally, C. Chilman, and F. Cox, eds., *Mental Illness, Delinquency, Addictions and Neglect: Families in Trouble Series*, Vol. 4, (Newbury Park, CA: Sage, 1988), 156.

82. J. Garbarino and E. Aaron, "The Significance of Ethnic and Cultural Differences in Child Maltreatment," *Journal of Marriage and the Family* 15(1983):773–783.

83. Crittenden and Ainsworth, "Child Maltreatment and Attachment Theory," 432–463; and V. Carlson et al., "Finding Order in Disorganization: Lessons from Research on Maltreated Infants' Attachments to their Caregivers," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment* (Cambridge: Cambridge University Press, 1989), 494–528.

84. J. L. Aber et al., "The Effects of Maltreatment on Development During Early Childhood: Recent Studies and Their Theoretical, Clinical and Policy Implications," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment* (Cambridge: Cambridge University Press, 1989), 579–619.

85. *Ibid.*

86. D. Hoffman-Plotkin and C. Twentyman, "A Multimodel Assessment of Behavioral and Cognitive deficits in Abused and Neglected Preschoolers," *Child Development* 55(1984):794–802.

87. Egeland, "The Consequences of Physical and Emotional Neglect on the Development of Young Children," D-14.

88. *Ibid.*, 14–15.

89. C. Howes and M. P. Espinoza, "The Consequences of Child Abuse for the Formation of Relationship with Peers," *Child Abuse and Neglect* 9(1985):397–404.

90. Aber et al., "The Effects of Maltreatment on Development During Early Childhood: Recent Studies and Their Theoretical, Clinical and Policy Implications," 579–619.

91. Egeland, "The Consequences of Physical and Emotional Neglect on the Development of Young Children," D-14–D-15.

92. Ibid., D-16–D-17.

93. J. S. Wodarski et al., "Maltreatment and the School-Age Child: Major Academic, Socioemotional and Adaptive Outcomes," *Social Work* 35(1990):506–513; and J. Eckenrode, M. Laird, and J. Doris, *Maltreatment and the Academic and Social Adjustment of School Children: Final Report* (Ithaca, NY: Family Life Development Center, Cornell University, 1990), 40, 55.

94. P. M. Crittenden, "Teaching Maltreated Children in Preschool," *Topics in Early Childhood Special Education* 9(1989):2; A. Frodi and J. Smetana, "Abused, Neglected and Nonmaltreated Preschoolers' Ability to Disseminate Emotions in Others: The Effects of IQ," *Child Abuse and Neglect* 8(1984):459–465; and P. T. Howing et al., "The Empirical Base for the Implementation of a Social Skills Training with Maltreated Children," *Social Work* 35(1990):460–467.

95. Wodarski et al., "Maltreatment and the School-Age Child: Major Academic Socioemotional and Adaptive Outcomes,"

96. Aber et al., "The Effects of Maltreatment on Development During Early Childhood," 579–619.

97. C. M. Mouzakitis, "An Inquiry into the Problem of Child Abuse and Juvenile Delinquency," in R. J. Honner and Y. E. Walker, eds., *Exploring the Relationships Between Child Abuse and Delinquency* (Montclair, NJ: Allanheld, Osmon & Co., 1981), 175–219; and L. B. Silver, C. C. Dubin, and R. S. Lourie, "Does Violence Breed Violence? Contributions from a Study of the Child Abuse Syndrome," *American Journal of Psychiatry* 126(1969):404–407.

98. J. D. Alfaro, "Report on the Relationship Between Child Abuse and Neglect and Later Socially Deviant Behavior," in R. J. Hunner and Y. E. Walker, eds., *Exploring the Relationship Between Child Abuse and Delinquency* (Montclair, NJ: Prentice-Hall, 1983), 191.

99. C. S. Widom, "Child Abuse, Neglect, and Violent Criminal Behavior," *Criminology* 1(1989):251–271.

100. P. T. Howing et al., "Child Abuse and Delinquency, The Empirical and Theoretical Links," *Social Work* 35(1990):244–249.

101. C. S. Widom, "Avoidance of Criminality in Abused and Neglected Children," *Psychiatry* 54(May 1991):162–174.

102. D. P. Kurtz et al., "The Consequences of Physical Abuse and Neglect on the School Age Child: Mediating Factors," *Children and Youth Services Review* (In Press).

103. M. Augoustinos, "Developmental Effects of Child Abuse: Recent Findings," *Child Abuse and Neglect* 11(1987):15–27.

104. American Humane Association, *Highlights of Official Child Neglect and Child Abuse Reporting: 1986*, 24.

105. L. Margolin, "Fatal Child Neglect," *Child Welfare* 69(1990):309–319.

106. *Ibid.*, 318.

107. J. D. Alfaro, *Studying Child Maltreatment Fatalities: A Synthesis of Nine Projects* (Unpublished Monograph, 1987).

108. Ibid., 44.

109. D. English and P. Pecora, *An Approach to Strength and Risk Assessment with Multi-Cultural Guidelines* (Seattle, WA: Department of Social and Health Services, Children's Services Research Project, 1992).

110. Polansky et al., *Damaged Parents*; and N. A. Polansky, "Determinants of Loneliness Among Neglectful and Other Low-Income Mothers," *Journal of Social Service Research* 8(1985):1–15.

111. Videka-Chairman, "Intervention for Child Neglect: The Empirical Knowledge Base," in *Research Symposium on Child Neglect* (Washington, DC: National Center on Child Abuse and Neglect, 1988), 60–61.

112. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

113. E. W. Lynch and M. J. Hanson, eds., *Developing Cross-Cultural Competence* (Baltimore: Paul Brooks Publishing, 1992).

114.W. Willis, "Families with African-American Roots," in E. W. Lynch and M. J. Johnson, eds., *Developing Cross-Cultural Competence* (Baltimore: Paul Brooks Publishing, 1992), 121–150; and C. Stack, *All Our Kin* (New York: Harper & Row, 1974).

115. Ibid.

116. Ibid.

117. Polansky et al., *Damaged Parents*.

118. N. A. Polansky et al. "Assessing the Adequacy of Child Caring: An Urban Scale," *Child Welfare* 57(1978):439–449.

119. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

120. S. Magura and B. S. Moses, *Outcome Measures for Child Welfare Services* (New York: Child Welfare League of America, 1986).

121. J. M. Gaudin, N. A. Polansky, and A. C. Kilpatrick, "The Child Well Being Scales: A Field Trial," *Child Welfare* 61(1992):319–328.

122. B. M. Caldwell and R. H. Bradley, *Administration Manual, Revised Edition: Home Observation for Measurement of the Environment* (Little Rock: University of Arkansas, 1984).

123. M. Watson-Perczel et al., "Assessment and Modification of Home Cleanliness Among Families Adjudicated for Child Neglect," *Behavior Modification* 12(1988):57–81.

124. J. R. Lutzker, "Behavioral Treatment of Child Neglect," *Behavior Modification* 14(1990):310.

125. *Ibid.*, 312.

126. D. A. Tertinger, B. F. Green, and J. R. Lutzer, "Home Safety: Development and Validation of One Component of an Ecobehavior Treatment Program for Abused and Neglected Children," *Journal of Applied Behavior Analysis* 17(1984):159–174.

127. Hartman, "Diagrammatic Assessments of Family Relationships," in B. Compton and B. Galaway, eds., *Social Work Processes*, 3rd ed., (Homewood, IL: Dorsey Press, 1984), 377–81.

128. E. M. Tracy and J. K. Whittaker, "The Social Network Map: Assessing Social Support in Clinical Practice," *Families in Society* (In Press); E. M. Tracy, "Identifying Social Support Resources of At-Risk Families," *Social Work* 35(1990):252–258; and Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

129. Burgess and Conger, "Family Interaction in Abusive, Neglectful and Normal Families," 1163–1173; Crittenden, "Abusing, Neglecting, Problematic, and Adequate Dyads: Differentiating by Patterns of Interaction"; Bousha and Twentyman, "Mother-Child Interactional Style in Abuse, Neglect, and Control Groups," 106–114.

130. Crittenden, "Family and Dyadic Patterns of Functioning in Maltreating Families," 165.

131. Ibid., 165.

132. S. C. Baird and D. Neufeldt, "Assessing Potential for Abuse and Neglect," *National Council on Crime and Delinquency Focus* (1988):1–7.

133. Crittenden, "Family and Dyadic Patterns of Functioning in Maltreating Families," 165.

134. M. S. Wald, "Risk Assessment: The Emperor's New Clothes?" *Child Welfare* 69(1990):483–511.

135. Ibid., 498.

136. D. English and P. Pecora, *An Approach to Strength and Risk Assessment with Multi-Cultural Guidelines* (Seattle, WA: Department of Social & Health Services, Children's Services Research Project, Management Services Division, 1992).

137. Nelson, Saunders, and Landsman, *Chronic Neglect in Perspective: A Study of Chronically Neglecting Families in a Large Metropolitan County.*

138. Polansky et al., *Damaged Parents*, 37–43.

139. J. K. Holtin, *Black Families and Child Abuse Prevention: An African American Perspective and Approach*, Working Paper No. 852, (Chicago: National Committee for Prevention of Child Abuse, 1990).

140. S. Fraiburg, E. Adelson, and L. V. Shapiro, "Ghosts in the nursery: A psychoanalytic approach to problems of impaired infant-mother relationships," *Journal of the American Academy of Child Psychiatry* 14(1970):387–421.

141. D. Daro, *Confronting Child Abuse* (New York: Free Press, 1988), 106–107.

142. *Ibid.*, 108–122; A. H. Cohn and D. Daro, "Is Treatment Too Late: What Ten Years of Evaluative Research Tell Us," *Child Abuse and Neglect* 11(1987):433–442; A. H. Cohn, "Essential Elements of Successful Child Abuse and Neglect Treatment," *Child Abuse and Neglect* (1979):491–496; and Videka-Chairman, "Intervention for Child Neglect: The Empirical Knowledge Base," 60–61.

143. J. R. Lutzker, R. E. Frame, and J. M. Rice, "Project 12-Ways: An Ecobehavioral Approach to the Treatment and Prevention of Child Abuse and Neglect," *Education and Treatment of Children*, 5(1982):141–156.

144. G. B. Mugridge, "Reducing Chronic Neglect," paper presented at Ninth National Conference on Child Abuse and Neglect (Denver: September 1991).

145. M. Sullivan, M. Spasser, and G. L. Penner, *The Bowen Center Project for Abuse and Neglected Children* (Washington, DC: Public Services Administration, Office of Human Development, 1977).

146. M. Andreini, "Chronic Neglect: Diagnosis and Treatment," paper presented at the Eighth International Congress on Child Abuse and Neglect (Hamburg, Germany: September 1990).

147. Daro, *Confronting Child Abuse*, 110.

148. Polansky et al., *Damaged Parents*, 196–197.

149. S. Bavolek and C. M. Comstock, *The Nurturing Program for Parents and Children* (Eau Claire, WI: Family Development Associates, 1983).

150. P. Rozansky and P. M. Chambers, *Final Report: Project TIME for Parents* (Washington, DC: National Center on Child Abuse and Neglect, 1982).

151. J. Kinney et al., "The HOMEBUILDERS Model," in E. M. Tracy et al., eds., *Intensive Family Preservation Services: An Instructional Source Book* (Cleveland, OH: Mandel School of Applied Social Sciences, 1991), 15–49.

152. K. E. Nelson, J. J. Landsman, and W. Deutelbaum, "Three Models of Family-Centered Placement Preventive Services," *Child Welfare* 69(1990):3–21.

153. *Ibid.*, 7.

154. E. C. Hinckley, "Homebuilders: The Maine Experience," *Children Today* (September 13, 1984):14–17.

155. Nelson, Landsman, and Deutelbaum, "Three Models of Family-Centered Placement Preventive Services," 8–9.

156. S. Maybanks and M. Bryce, *Home-Based Services for Children and Families: Policy, Practice and Research* (Springfield, IL: Charles C. Thomas, 1979).

157. Y. T. Yuan and D. L. Struckman-Johnson, "Placement Outcomes for Neglected Children with Prior Placements in Family Preservation Programs," in M. Kathleen Wells and David E. Bigel, eds., *Family Preservation Services: Research and Evaluation* (Newbury Park, CA: Sage, 1991), 92–118.

158. Daro, *Confronting Child Abuse*, 109; and Cohn, "Essential Elements of Successful Child Abuse and Neglect Treatment," 493–494.

159. *Ibid.*, 493.

160. Daro, *Confronting Child Abuse*, 111.

161. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

162. J. Aderman and T. Russell, "A Constructivist Approach to Working with Abusive and Neglectful Parents," *Family Systems Medicine* 8(1990):241–250.

163. M. J. Landsman et al., *The Self-Sufficiency Project: Final Report* (Iowa City, IA: National Resource Center in Family Based Services, 1992).

164. S. Bavolek and C. M. Comstock, *The Nurturing Program for Parents and Children* (Park City, UT: Family Resources Development, Inc., 1983).

165. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

166. Daro, *Confronting Child Abuse*, 111.

167. Sullivan, Spasser, and Penner, *The Bowen Center Project for Abused and Neglected Children*; and Lutzker, Frame, and Rice, "Project 12-Ways: An Ecobehavioral Approach to the Treatment and Prevention of Child Abuse and Neglect," 141–155.

168. Videka-Chairman, "Intervention for Child Neglect: The Empirical Knowledge Base," 54–59.

169. Bavolek and Comstock, *The Nurturing Program for Parents and Children*; and *The Small Wonder Kit* (Circle Pines, MN: American Guidance Services, 1982).

170. Lutzker, "Behavioral Treatment of Child Neglect," 312.

171. P. T. Howing et al., "Effective Interventions to Ameliorate the Incidence of Child Maltreatment: The Empirical Base," *Social Work* 34(1989):331.

172. A. Edgington and M. Hall, "Dallas Children and Youth Project Child Neglect Demonstration Grant," NCCAN Grant #90-C-1688, (Dallas: University of Texas Health Services Center, 1982), 27.

173. Videka-Chairman, "Intervention for Child Neglect: The Empirical Knowledge Base," 59.

174. Kinney et al., "The HOMEBUILDERS Model," 15–49.

175. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

176. Polansky et al., "The Psychological Ecology of the Neglectful Mother," 265–275; and Crittenden, "Family and Dyadic Patterns or Functioning in Maltreating Families," 161–189.

177. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 103–105.

178. *Ibid.*, 97–123; Cohn, "Essential Elements of Successful Child Abuse and Neglect Treatment," 491–496; and Cohn and Daro, "Is Treatment Too Late: What Ten Years of Evaluative Research Tell Us," 433–442.

179. Videka-Chairman, "Intervention for Child Neglect: The Empirical Knowledge Base," 54–59; and K. Miller et al., "A Parent-Aide Program: Record-Keeping, Outcomes and Costs," *Child Welfare* 64(985):407–419.

180. H. Yahraes, *Teaching Mothers Mothering* (Rockville, MD: National Institutes of Mental Health, 1977).

181. Cohn and Daro, "Is Treatment Too Late: What Ten Years of Evaluative Research Tell Us," 437.

182. *Ibid.*, 439.

183. Daro, *Confronting Child Abuse*, 112–121.

184. Howing et al., "The Empirical Base for the Implementation of a Social Skills Training with Maltreated Children," 460–467.

185. Daro, *Confronting Child Abuse*, 115.

186. Berkeley Planning Associates, *Therapeutic Child Care: Approaches to Remediating the Effects of Child Abuse and Neglect: Evaluation of the Clinical Demonstration Prospects on Child Abuse and Neglect*, Report prepared for the National Center on Child Abuse and Neglect, (February 1982).

187. Wodarski et al., "Maltreatment and the School-Age Child: Major Academic, Socioemotional and Adaptive Outcomes," 506–513.

188. Daro, *Confronting Child Abuse*, 114.

189. M. S. Steward et al., "Group Therapy: A Treatment of Choice for Young Victims of Child Abuse," *International Journal of Group Psychotherapy* 36(2):261–277.

190. U.S. Congress, Senate Subcommittee on Human Resources, Hearings, Washington, DC, 1990.

191. M.S. Wald "State Intervention on Behalf of Neglected CHildren: Standards for Removal," (1976):636–706.

192. U.S. Congress, *Child Welfare Act of 1980* (P. L. 96–272).

193. D. English and S. W. Aubin, "Outcomes for Screened-Out and Low Risk Cases Within a Child Protective Services (CPS) Risk Assessment System," paper presented at Fourth National Roundtable on CPS Risk Assessment, San Francisco, August 1990, 3.

194. J. C. Harris and B. E. Bernstein, "The Lawyer and Social Worker As A Team: Preparing for Trial in Neglect Cases," *Child Welfare* 59(1980):469–477.

195. Polansky et al., *Damaged Parents*, 40.

196. J. Arches, "Social Structure, Burnout, and Job Satisfaction," *Social Work* 36(1991):202–206.

197. C. Shannon and D. Saleebey, "Training Child Welfare Workers to Cope with Burnout," *Child Welfare* 59(1980):463–468.

198. Arches, "Social Structure, Burnout and Job Satisfaction," 202–206.

199. M. C. Raider, "Burnout in Children's Agencies," *Residential Treatment for Children and Youth* 6(1989):48.

200. U.S. Department of Health and Human Services, *Study of National Incidence and Prevalence of Child Abuse and Neglect*,5–43.

201. U.S. Congress, House of Representatives Select Committee on Children, Youth and Families, *Current Conditions and Recent Trends, 1989*, (Washington, DC: Government Printing Office, 1989), 109.

202. B. Brown, ed., *Found: Long Term Gains from Early Intervention* (Boulder, CO: Westview Press, 1978).

203. L. J. Schweinhart and D. P. Weikart, "The High/Scope Perry Preschool Study: Implications for Early Childhood Care and Education," in R. P. Lorion, ed., *Protecting the Children: Strategies for Optimizing Emotional and Behavioral Development, Prevention in Human Services* 7(1990):111–132.

204. D. L. Johnson, "The Houston Parent-Child Development Project: Dissemination a Viable Program for Enhancing At-Risk Families," in R. P. Lorion, ed., *Protecting the Children: Strategies for Optimizing Emotional and Behavioral Development, Prevention in Human Services* 7(1990):89–108.

205. C. T. Ramey et al., "Early Intervention for High-Risk Children: The Carolina Early Intervention Program," in R. P. Lorion, ed., *Protecting the Children: Strategies for Optimizing Emotional and Behavioral Development, Prevention in Human Services* 7(1990):33–58.

206. Schweinhart and Weikart, "The High/Scope Perry Preschool Study: Implications for Early Childhood Care and Education," 115.

207. Daro, *Confronting Child Abuse*, 66.

208. D. Olds et al., "Preventing Child Abuse and Neglect: A Randomized Triology Nurse Home Visitation," *Pediatrics* 78(1986):65–78.

209. L. Fuddy, "Hawaii's Healthy Start Successful in Preventing Child Abuse," paper presented at Ninth International Congress on Child Abuse and Neglect, Chicago 1992.

210. J. Gray and B. Kaplan, "The Lay Health Visitor Program: An Eighteen-Month Experience," in C. H. Kempe and R. E. Helfer, eds., *The Battered Child*, 3d. ed., (Chicago: University of Chicago Press, 1980), 373–378; R. Helfer, "An Overview of Prevention," in R. E. Helfer and R. S. Kempe, eds., *The Battered Child*, 4th ed., (Chicago: University of Chicago Press, 1987), 428–429; and C. Steele and S. Wood, *First Steps Operational Manual* (Atlanta: Georgia Council on Child Abuse, 1991).

211. Egeland and Erickson, "Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect," 29–35.

212. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123; and J. M. Gaudin and P. D. Kurtz, "Parenting Skills Training for Child Abusers," *Journal of Group Psychotherapy and Psychodrama* 36(1985):35–54.

213. R. F. Dangel and R. A. Polster, "WINNING! A Systematic Empirical Approach to Parent Training," in R. A. Polster and R. F. Dangel, eds., *Parent Training: Foundations of Research and Practice* (New York: Guilford Press, 1984).

214. Bavolek and Comstock, *The Nurturing Program for Parents and Children*.

215. Daro, *Confronting Child Abuse*, 133.

216. The Small Wonder Kit.

217. M. A. Feldman et al., "Parent Education Project II: Increasing Stimulating Interactions of Developmentally and Handicapped Mothers," *Journal of Applied Behavior Analysis* 19(1986):23–37.

218. Gaudin et al., "Remedying Child Neglect: Effectiveness of Social Network Interventions," 97–123.

219. H. Adamakos, K. Ryan, and D. G. Ullman, "Maternal Social Support as a Predictor of Mother-Child Stress and Stimulation," *Child Abuse and Neglect* 10(1986):463–210.

220. Daro, *Confronting Child Abuse*, 112.

221. Cohn and Daro, "Is Treatment Too Late: What Ten Years of Evaluation Research Tell Us," 433–442.

222. Daro, *Confronting Child Abuse*, 127.

223. A. Kahn, *Social Policy and Social Services*, 2d. ed., (New York: Random House, 1979), 75–76.

224. Children's Defense Fund, *The State of America's Children: 1991* (Washington, DC.: Children's Defense Fund, 1991), 56.

225. G. M. Gazda, W. C. Childers, and D. K. Brooks, *Foundations of Counseling and Human Services* (New York: McGraw-Hill, 1987), 133–244.

226. S. J. Zuravin, "Child Abuse, Child Neglect and Maternal Depression: Is There a Connection?" in *Research Symposium on Child Neglect* (Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1988), D-34.

227. Wodarski et al., "Maltreatment and the School-Age Child: Major Academic, Socioemotional and Adaptive Outcomes," 506–513.

228. J. Knitzer, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Service* (Washington, DC, Children's Defense Fund, 1982).

229. *Ibid.*, 50–51.

230. *Ibid.*, 34.

231. Daro, *Confronting Child Abuse*, 132; E. Gray, "Early Parenting Intervention to Prevent Child Abuse: A Meta-Analysis: Executive Summary," paper presented at Research Grantees Meeting, National Center on Child Abuse and Neglect, Washington, DC, March 1991.

SELECTED BIBLIOGRAPHY

GENERAL OVERVIEWS OF CHILD MALTREATMENT

American Prosecutors Research Institute. "Is This Criminal Neglect?" *UPDATE* 5(April–May):2.

Barth, R. P., and Sullivan, R. "Collecting Competent Evidence in Behalf of Children." *Social Work* 30(March–April 1985):130–136.

Brown, W. K., and Newnam, T. A. *Emotional Abuse and Neglect of Children*. Huntington, NY: William Gladden Foundation, 1990.

Cantwell, H. B. *Standards of Child Neglect*. rev. ed. Denver CO: Colorado Department of Social Services, 1988.

Channing L. Bete Co., Inc. *About Emotional Abuse and Neglect of Children*. South Deerfield, MA: Channing L. Bete Co., Inc., 1991.

Cohn, A. H. *It Shouldn't Hurt to Be a Child*. rev. ed. Chicago: National Committee for Prevention of Child Abuse, 1987.

Coleman, L., Partridge, S., and Partridge, R. *Unattended Children*. Portland, ME: Human Services Development Institute University of Southern Maine, 1987.

Dukes, R. L., and Kean, R. B. "An Experimental Study of Gender and Situation in the Perception and Reportage of Child Abuse." *Child Abuse and Neglect* 13(1989):351–360.

Dulcan, M. K., and Popper, C. W. *Special Clinical Circumstances*. Washington, DC: American Psychiatric Press, Inc., 1991.

Elmer, E. "Etiology of Emotional Maltreatment." In *Social Work Treatment With Abused and Neglected Children*, edited by C. M. Mouzakitis and R. Varghese. Springfield, IL: Charles C. Thomas Publisher, 1985.

Garbarino, J., and Vondra, J. "Psychological Maltreatment: Issues and Perspectives." In *Psychological Maltreatment of Children and Youth*, edited by M. R. Brassard, R. Germain, and S. N. Hart. New York: Pergamon Press, 1987.

Garfinkel, L., Gorka, C., Murphy, C., Goldberg, P. F., et al. *A Resource Manual on Child Abuse*. Minneapolis, MN: PACER Center, Inc., 1985.

Green, A. H. *Child Neglect*. New York: Plenum Press, 1991.

Hart, S. N.; Gelardo, M.; and Brassard, M. "Psychological Maltreatment." In *Psychiatric Sequelae of Child Abuse*, edited by J. J. Jacobson. Springfield, IL: Charles C. Thomas, Publisher, 1986.

Hegar, R. L., and Yungman, J. J. "Toward a Causal Typology of Child Neglect." *Children and Youth Services Review* 11(1989):203–220.

Helfer, R. E. "The Neglect of Our Children." *World and I* 5(June 1990):531–541.

Holm, M. F. *Shall the Circle Be Unbroken?* Longmont, CA: Bookmakers Guild Inc., 1986.

Jacoby, S. "Emotional Child Abuse: The Invisible Plague." *Empathic Parenting* (Summer 1986):3–6.

Johnson, E. W. "Educational Neglect as a Proper Harm to Warrant a Child Neglect Finding: In re B. B." *Iowa Law Review* 76(October 1990):167–186.

Junewicz, W. J. "Treatment of Child Emotional Maltreatment." In *Social Work Treatment With Abused and Neglected Children*, edited by C. M. Mouzakitis and R. Varghese. Springfield, IL: Charles C. Thomas Publisher, 1985.

Kadushin, A. "Neglect in Families." In *Mental Illness, Delinquency, Addictions, and Neglect*, edited by E. W. Nunnally, C. S. Chilman, and F. M. Cox. Newbury Park, CA: Sage Publications, 1988.

Kfoury, P. R., and Bizios, C. B. "Medical Treatment of Children." *New Hampshire Bar Journal* 29(Fall 1987):29–47.

Lutzker, J. R. "Behavioral Treatment of Child Neglect." *Behavior Modification* 14(July 1990):301–315.

McMahon, E. T.; Zimmer, J. A.; Modglin, T. W.; and O'Neil, J. F. *Child Abuse*. St. Paul, MN: West Publishing Co., 1992.

Pelton, L. H. "Poverty and Child Protection." *Protecting Children* 7(Winter 1990–1991):3–5.

Polansky, N. A.; Gaudin, J. M., Jr.; and Kilpatrick, A. C. "Family Radicals." *Children and Youth Services Review* 14(1992):19–26.

Schakel, J. A. "Emotional Neglect and Stimulus Deprivation." In *Psychological Maltreatment of Children and Youth*, edited by M. R Brassard, R. Germain, and S. N. Hart. New York: Pergamon Press, 1987.

Scheiderer, J. I. "When Children Die as a Result of Religious Practices." *Ohio State Law Journal* 51(November 1990):1429–1445.

Szur, R. "Emotional Abuse and Neglect." In *The Education Perspective*, edited by P. Maher. Oxford, England: Basil Blackwell Limited, 1987.

Westman, J. C. *Who Speaks for the Children? A Handbook of Individual and Class Child Advocacy*. Sarasota, FL: Professional Resource Exchange, Inc., 1991.

Wissow, L. S. "Neglect." In *An Approach to Child Abuse and Neglect*. Baltimore, MD: Williams and Wilkins, 1990.

Zuravin, S. J. "The Ecology of Child Abuse and Neglect: Review of the Literature and Presentation of Data." *Violence and Victims* 4(Summer 1989):101–120.

RESEARCH METHODOLOGY/ASSESSMENT

Andreini, M., and Mangiardi, P. *Diversified Intervention Project: Diagnosing and Treating Chronic Child Neglect. Supplemental Research. Barriers to Success: Difficulty in Treating Chronic Neglect.* Anchorage, AK: Anchorage Center for Families, 1991.

Bavolek, S. J. *Research and Validation Report of the Nurturing Programs. Effective Family-Based Approaches to Treating and Preventing Child Abuse and Neglect.* Eau Claire, WI: Family Development Resources, Inc., 1990.

Child Abuse and Neglect. "Recommendations for the 21st Century." *Child Abuse and Neglect* 15(1991):39–50.

Conley, W. D. *Children at Risk: Cognitive Functioning Across Different Forms of Maltreatment.* Phoenix, AZ: Arizona Department of Economic Security, 1989.

Eastern Kentucky University. *Professionals Together: Intervening with Neglectful Families.* Frankfort, KY: Kentucky State Department for Social Services, 1989.

Egeland, B., and Erickson, M. F. "Psychologically Unavailable Caregiving." In *Psychological Maltreatment of Children and Youth*, edited by M. R. Brassard, R. Germain, and S. N. Hart. New York: Pergamon Press, 1987.

Garbarino, J., and Garbarino, A. C. *Emotional Maltreatment of Children.* 2nd ed. Chicago: National Committee for Prevention of Child Abuse, 1986.

Gaydin, J. M., Jr.; Polansky, N. A.; and Kilpatrick, A. C. "The Child Well-Being Scales: A Field Trial." *Child Welfare* 71(July–August):319–328.

Gil, E. *The Healing Power of Play. Working With Abused Children.* New York: Guilford Press, 1991.

National College of Juvenile and Family Law. *Judicial Authority and Responsibility: 18 Recommendations on Issues in Delinquency and Abuse–Neglect Dispositions.* Reno, NV: National College of Juvenile and Family Law, 1989.

Rattenberg, K. R., and MacPhee, D. "Conception of Abuse: Legal vs. Research Definitions and Policy Implications." In *New Directions in Child and Family Research: Shaping Head Start in the 90's. First National Working Conference on Early Childhood and Family Research, Arlington, VA, June 24–26, 1991*, edited by F. L. Parker, R. Robinson, S. Sambrano, C. Piotrkowski, et al. Washington, DC: U. S. Department of Health and Human Services, Administration on Children, Youth and Families, 1992.

Rosenthal, J. A.; Motz, J. K.; Edmonson, D. A.; and Groze, V. "A Descriptive Study of Abuse and Neglect in Out-of-Home Placement." *Child Abuse and Neglect* 15(1991):249–260.

U. S. Department of Health and Human Services. National Center on Child Abuse and Neglect. *National Center on Child Abuse and Neglect Research Symposium on Child Neglect. February 23–25, 1988.* Washington, DC: Government Printing Office, 1989.

Zuravin, S. J. "Research Definitions of Child Physical Abuse and Neglect: Current Problems." In *The Effects of Child Abuse and Neglect. Issues and Research*, edited by R. H. Starr, Jr., and D. A. Wolfe. New York: Guilford Press, 1991.

SPECIAL POPULATIONS

Ammerman, R. T.; Van Hasselt, V. B.; Hersen, M.; McGonigle, J. J.; and Lubetsky, M. J. "Abuse and Neglect in Psychiatrically Hospitalized Multihandicapped Children." *Child Abuse and Neglect* 13(1989):335–343.

Besharov, D. J. "The Misuse of Foster Care: When the Desire to Help Children Outruns the Ability to Improve Parental Functioning." In *Protecting Children From Abuse and Neglect. Policy and Practice*, edited by D. J. Besharov. American Series in Behavioral Science and Law. Springfield, IL: Charles C Thomas, Publisher, 1988.

Craft, J. L., and Staudt, M. M. "Reporting and Founding of Child Neglect in Urban and Rural Communities." *Child Welfare* 70(May–June):359–370.

Groce, N. E. "Special Groups at Risk of Abuse: The Disabled." In *Abuse and Victimization Across the Life Span*, edited by M. B. Straus. Johns Hopkins Series in Contemporary Medicine and Public Health. Baltimore, MD: Johns Hopkins University Press, 1988.

Jaudes, P. K., and Diamond, L. J. "Neglect of Chronically Ill Children." *American Journal of Diseases of Children* 140(July 1986):655–658.

Kline, D. F.; Kline, A. C. *The Disabled Child and Child Abuse*. 2nd ed. Chicago: National Committee for Prevention of Child Abuse, 1987.

Leventhal, J. M.; Garber, R. B.; and Brady, C. A. "Identification During the Postpartum Period of Infants Who Are at High Risk of Child Maltreatment." *Journal of Pediatrics* 114(March 1989):481–487.

Lujan, C.; DeBruyn, L. M.; May, P. A.; and Bird, M. E. "Profile of Abused and Neglected American Indian Children in the Southwest." *Child Abuse and Neglect* 13(1989):449–461.

Northwest Indian Child Welfare Association, Inc. *Walking in Your Child's Moccasins. A Booklet About Child Abuse and Child Neglect for Parents and Caregivers of Indian Children*. Portland, OR: Northwest Indian Child Welfare Association, Inc., 1990.

PACER Center, Inc. *Let's Prevent Abuse*. Minneapolis, MN: PACER Center, Inc., 1989.

Sobsey, D.; Gray, S.; Wells, D.; Pyper, D.; and Reimer-Heck, B. *Disability, Sexuality, and Abuse. An Annotated Bibliography*. Baltimore, MD: Paul H. Brookes Publishing Co., 1991.

Zuravin, S. J., and Starr, R. H., Jr. "Psychosocial Characteristics of Mothers of Physically Abused and Neglected Children: Do They Differ by Race?" In *Black Family Violence. Current Research and Theory*, edited by R. L. Hampton. Lexington, MA: Lexington Books, 1991.

STATE/REGIONAL STUDIES

Allen, M.; Reiter, J.; and Landsman, M. "The Self-Sufficiency Project: New Motivation for Neglectful Families." Oakdale, IA: National Resource Center on Family Based Services, 1989.

Baily, T. F., and Baily, W. H. *Operational Definitions of Child Emotional Maltreatment. Final Report*. Augusta, ME: Department of Human Services, EM Project, 1986.

Bruce, M. "Emotional Neglect." In *Child Abuse and Neglect Law: A Canadian Perspective*, edited by D. J. Besharov. Washington, DC: Child Welfare League of America, Inc., 1985.

Casto, R. M. *Child Abuse and Neglect Interdisciplinary Program*. Columbus, OH: Ohio State University Research Foundation, 1991.

Indiana State Board of Health. *A 1990 Assessment of the Physical Abuse and Neglect and Sex Offense Service Resources in Indiana. Final Report*. Indianapolis, IN: Indiana State Board of Health, 1991.

Margolin, L. "Fatal Child Neglect." *Child Welfare* 69(July–August 1990):309–319.

Nelson, K.; Saunders, E.; and Landsman, M. J. *Chronic Neglect in Perspective: A Study of Chronically Neglecting Families in a Large Metropolitan County. Final Report*. Oakdale, IA: National Resource Center on Family Based Services, 1990.

Virginians for Child Abuse Prevention, Inc.; Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. Children's Resource Center. *On Behalf of Virginia's Children. A Briefing Booklet for Advocates and Legislators During the 1992 General Assembly Session*. Richmond, VA: Virginians for Child Abuse Prevention, Inc., 1992.

ADULT SURVIVORS

Brown, P., and Jones, E. D. *Help for Adult Survivors of Childhood Abuse*. Chicago: National Committee for Prevention of Child Abuse, 1990.

Zweig-Frank, H., and Paris, J. "Parents' Emotional Neglect and Overprotection According to the Recollections of Patients with Borderline Personality Disorder." *American Journal of Psychiatry* 148(May 1991):648–651.

OTHER RESOURCES

PROFESSIONAL ASSOCIATIONS

American Academy of Pediatrics
141 Northwest Point Boulevard
P.O. Box 927
ELk Grove, IL 6009-0927
800/433-9016

American Association of Marriage and Family Therapy
1100 17th Street, N.W.
Washington, DC 20036
202/452-0109

American Professional Society on the Abuse of Children
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
312/554-0166

American Psychiatric Association
1400 K Street, N.W.
Washington, DC 20005
202/682-6000

American Psychological Association
750 First Street, N.E.
Washington, DC 20002-4242
202/336-5500

Child Welfare League of America
440 First Street, N.E.
Suite 310
Washington, DC 2001-2085
202/638-2952

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
703/385-7565

National Association of Counsel for Children
1205 Oneida Street
Denver, CO 80220
303/321-3963

National Association of Social Workers
750 First Street, N.E.
Suite 700
Washington, DC 20002
202/408-8600

Parents Anonymous
6733 South Sepulveda Boulevard
Suite 270
Los Angeles, CA 90045
800/421-0353

People of Color Leadership Institute
714 G Street, N.E.
Washington, DC 20003
202/544-3144

PROFESSIONAL JOURNALS

Journals Specific to Family Violence

Child Abuse and Neglect: The International Journal

Journal of Child Sexual Abuse

Journal of Family Issues

Journal of Family Violence

Journal of Interpersonal Violence

Psychology of Women Quarterly

Violence and Victims

Related Journals

American Journal of Family Relations

American Journal of Orthopsychiatry

Archives of Sexual Behavior

Child Welfare

Children and Youth Services Review

Criminal Justice and Behavior: An International Journal

Journal of Social Issues

Pediatrics

Professional Psychology: Research and Practice

Psychotherapy

Social Casework

Social Work